			1 - State Registrar	Adiadalla Lao		of Marylar		artment rtificate					Reg. No.	20	004	150	0 !
	Physici /Medi		Decedent's Name (First,     Josephine E	arrie								April	23,	, 2	Year 2004	5:58 p	
100	Examir	ner	4a. Facility Name (If not ins					4b. City,		Location Lumbi			4c.	County			
	Funeral		Howard Cour 5. Social Security Number	6. Se	эх	7. Age (In yrs.		If Under Months		If Under Hours		8. Date of Bir (Month, Da	th V Year)	_HO	Ward  9. Birthpli Count	ace (State or Fore	eign
1	Director		153-05-5448		□M 2 <del>Q</del> F	83	Yrs.	WORKIS	Days	110013	14111.	Sep. 1		20		NJ	
	/land		Usual Residence of Deced 10a. State 10b. 0	County		10c. Cit	ty, Town or Lo	cation					-		10	d. Inside City Lin	nits
	e Mar	ctor	MD	Howar	rd			Cc	olum	bia						1 Yes 24	No
	with th	Dire	10e. Street and Number 7070 Cradle	Walkw	72.17			10f. Zip		046			10g. Citi:	en of W	hat Count USA	ry?	
	filed within 72 hours after death with the Maryland Hygiene. sither than "natural", or Items 23a or 28e-f show ant, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	WALK	12. Was Dec	edent Ever in U	.S. 13.	Was Deced			igin? (Spe	ecify Yes or No Rican, etc.)	)~		- America		
ထ္	after or Iten		1 Never Married 2		Armed F 1 ☐ Yes If Yes, G	2 No		If Yes, spec 1 ☐ Yes 2		n, Mexicai Specify:		Hican, etc.)		Black Specify:	k, White, e . W.	hite	
21215-0036	hours tural',	ed by	3 XWidowed 4 Dr	orced cedent's Ed	Year or I	Dates:		dent's Usua							siness/Ind	ustry	
75	hin 72	Completed		highest gra	de completed;	1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired	during mos	it of worki	ng	100.11				
2	filed within Hygiene. other than ont, it a	Сош	12					Но	mema						Но	me	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, Items	To Be	17. Father's Name (First, A Peter Wich								er's Name heri:	ne (Eirst, Middle	, <sub>Maiden</sub> Jnava				
lary	2 should and Men Is marker	-	19a. Informant's Name/Re									A Route Numb					
	1 and 2 Health em 27		Joseph Barr	cie, J	r./Son	20h F	786 Place of Dispo	A DESCRIPTION OF THE PARTY OF T		Driv		illersv			City or To	108	
nor	Pages nent of H ant: If ite		20a. Method of Disposition  1 Burial 2 Crem  4 Donation 5 0			State	etro C	matory`or o	ther plac	e)	Apr.	28,			ore,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, If a Medical Examiner must be notified at 2008.		21. Signature of Funeral S			les	B	2. Name an	d Addres	Sons	P.	004 A. Seve	erna	Park	. Fun	eral Hom 21146	—— 1e
A.			23a. Part Enter the diese shock, of heart allur Immediate Cause (Final	ase, or comp b. List only	olications that	caused the dear	th. Do not en	ter the mod	e of dying	g, such as	cardiac	y, Seve or respiratory a	rrest,			Approximate Interval Between Onset and Death	1
	Physician /Medical		disease or condition resulting in death)	-	a. Due to	Mali (or as a consec Atuno	Swant	7	res	Jan	es a				-	udder	1
8	Examiner		Sequentially list conditions	- 1	b	Aturo	3 cles	Total	con	dio	Mou	e les cl	so.	ne	9	1800	
	pe sit	niner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	·₹	Due to	(or as a consec	uence of):								/		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	sai Examiner	that initiated events resulting in death) Last	l	c. Due to	(or as a consec	quence of):										
9	n certificate anding phy use as the	/Medic	IF FEMALE:		23c If yes or	itcome of pregn	ancy						Τ,	and Dat	e of delive		
P.O. Box	at the death certif by the attending tached for use a:	Physician/Medical	23b. Was decedent pregn: in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	unt	1 Live	birth 2 ☐ Feta nant at time of c	al déath 3	⊒Ectopic pr ⊒ Other (sp	,					Mor		Day Year	
	uires that the signed by the detaction	by	Part II. Other significant c				sulting in the u	_	ausę give		l.			_		e cause of death	
Records,	The law requir ate has been si page 2 should I	Completed											psy ormed?	p	rior to cor leath?	osy findings availanted	
	sicien: Th certificate rector, pag	0	25. Was case referred to n	nedical						26. Plac	e of Deatl	1 ☐ Yes		1	☐ Yes	2 No	
Š	Physicien: r this certifica ral director, I	To B	examiner? 1 Yes 2 No		Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DC	A Othe	or		me 5□Res		3 □Othe	er (Specify	)	
o uo	ing Affe			Pending nvestigation		of Injury oth, Day Year)	28b. Time o Injury	of 2	8c. Injury Work	yat k? Yes 2 [		28d. Describe	how injur	y occurre	ed		
Division of Vital	I or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐	Could not be determined	28e. Plac	e of Injury - At h ling, etc. (Speci						28f. Location ( City or To			er or Rura	l Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical C			າiກ <b>ອ</b> າ: On the I	e best of my kno casis of examina oner stated.	ation and/or in		in many as	ainian da	ath agains	and at the time	data and	I place o	and due to	the equec(c)	
	To th within To th compl	Me	29b. Signature and title of	ertifier	1			290	. License	e number			29d. Dat	e signed	(Month, i	Day, Year)	
			1	1				1	12	28	76		14	nic	21	, 200 /	
			30. Name and address of p		completed cau	se of death (Ite	m 23a) (Type,	Print)	te Ra	reta	1 Pl	, Ca	Leno.	4	may	Day, Year) 2004 Crul 20	047
*	Sta Registr	1.1	31. Date filed (Month, Day,	Year) 2 8	2004 32.1	Redistrar's Sign	ature	Smile	ر								

		Registrar  1. Decedent's Name (First, Middle, La.	st)	Cel	rtificate of l	Jealii	2. Date of Death	g. No.	104	3. Time o	f Death
hysician	1	William Joseph					April 2		Year 1	4:00	A
/Medical xaminer		a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	ripiti 2	4c. County		4.00	
Adminici		920 Barnegat I	ane		Annapo	olis		Anne	e Aru	ndel	
eral	5	5. Social Security Number 6. S	ex 7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		lace (State of	or Fore
or	ļ.	127-07-4406  Usual Residence of Decedent	83	Yrs.			May 30,	1920	New	York	
	_	10a. State 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside C	ity Limi
ţ	5	Maryland Anne Ar	undel		Annapoli	is				1 🗌 Yes	2 <b>X</b> i
or other freumelic event, the Mudical Examiner must be nutilised at	3	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhat Coun	try?	
Funeral Director		920 Barnegat Lan	e		21401			Ţ	JSA		
lue	1	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		- America		
bv Fi		1 Never Married 2 Married	1 X Yes 2 No If Yes, Give 1043		1 ☐ Yes 2 🔀 No		,,	Specify		ite	
d be	-	3 Widowed 4 Divorced  15. Decedent's Ed	Year or Dates: 1942—		footin Lloval Occupa	ulina					
Completed	-	(Specify only highest gra	de completed)	(Give	ient's Usual Occupa kind of work done o DO NOT use retired	ation furing most of worki )	ng 1	6b. Kind of Bu	siness/Ind	lustry	
Omc		Elementary/Secondary (0-12)	College (1-4or 5+) 4 yrs.		ostmaster			US Pos	tal 9	Servio	7 <b>0</b>
BeC	1	17. Father's Name (First, Middle, Last)			000.000	18. Mother's Name	(First, Middle, M			OCT VIC	
ToB	3	Nazary Bezw	ersky			Kathe	erine Mat	tyaszek			
		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	g Address (Street a	and Number or Rura	l Route Number,	City or Town,	State, Zip	Code)	
once.		Margarite E. Bezw	ersky/ Wife	920	Barnegat	Ln., Anna	polis. M	Marvlan	d 214	401	
	2	20a. Method of Disposition 1XX6urial 2 ☐ Cremation 3 ☐	20b. Pla	ace of Dispo	sition (Name of natory or other place	9)		Oc. Location -			
		'4 □Donation 5 □Other (Specif)	Intellioval Holli State		Cemetery	l l	)4 I	Davidso	nvil	le, MI	)
9000		21. Signature of Funeral Service Licen	see	22	. Name and Addres	s of Facility Geo	orge P. 1	Kalas F	unera	al Hon	ne
a		23a. Part1. Enter the disease, or comp shock, or heart failure. List only		2	973 Solon	ions Islar	nd Rd. Ed	gewate	er, M	2103	57
an la		disease or condition resulting in death)  Sequentially list conditions, fam, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.	erice of):	Canc						
cal			d								
Me	t	IF FEMALE:	23c. If yes, outcome of pregnan	finiti-	-			_	-		
Physician/Medi		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fetal of 4 Pregnant at time of dec	death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of deliver th	-	/ear
by Pi	F	Part II. Other significant conditions of	ontributing to death but not resul	Iting in the un	nderlying cause give	n in Part I.	23e. Did toba	icco use contri	bute to the	cause of d	eath?
ieted b							1 ☐ Yes	2 □ No	3 🗌 Proba	ibly 4 🗀 L	Inknov
Completed					-		24a. Was an	24b. W	/ere autop	sy findings :	availab
, Eo	I						autopsy performe	ed? d	eath?	pletion of ca 2⊠No	ause o
To Be Com		25. Was case referred to medical				26. Place of Death				INO	
70 8		examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	3 DOA Othe	r. 4 Nursing Hon	ne 5 Mesiden	ce 6 Othe	r (Specify)		
		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at 2	8d. Describe how				
Certification:		3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office	2	8f. Location (Stre City or Town,	et and Numbe State)	r or Rural	Route Num	ber,
Medical Ce		29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my know hiner: On the basis of examination	viedge, death on and/or inv	occurred at the timestigation, in my op	e, date and place, a inion, death occurre	nd due to the cau d at the time, dat	ise(s) and mar e and place, a	ner as sta nd due to t	ted. the cause(s	)
Me	2	29b. Signature and title of certifier			29c. License	number	290	d. Date signed	(Month, D	ay, Year)	
		itX D	The		Dan	21701	1	1001	7 0	7 .7 )	
		400	· IV MAI		1/(3/30	(501	2	14. 11	2	0000	-

			_ For								ental Hyg	iene 💂	0.1	15000
			_ State Registrar			Cer	tificate	e of E	Death			rg. 140.	04	15005
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last Robert Smith BAZI	LUKE			44 - 141				2. Date of Death	Day	2004	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Washington County				-		Location of	of Death		4c. County Wash	of Death ingto	n
	Funeral Director		Social Security Number 6. Se			last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Feb. 1,	<sup>Year)</sup> 1923	9. Birthp Coun Ver	lace (State or Foreign try) mont
	yland now		Usual Residence of Decedent  10a. State  10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
	Ba-f st	ector	Maryland Washing	gton			Hager		m			On Citizen of	Mhat Caus	1 ☐ Yes 2 🖾 No
	n with th	al Dire	10e. Street and Number 20014 Rosebank Wa	ay, Apt.	323		10f. Zip		742			og. Citizen of USA		ntry ?
36	rs after deatl	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 ☑ Yes 2 If Yes, Give Year or Date	es? □ No Tutu		Was Deced i Yes, spec			gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ck, White,	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23e or 28e-f show or other traumatic avant, the Medical Eyartii at must be colified at	Completed	15. Decedent's Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4	or 5+)	life. I	dent's Usua kind of wor DO NOT us inist	rk done d se retired)	luring mos	t of worki	ng	16b. Kind of 8	usiness/Ind	
and 5	uld be filed v Aental Hygie rked other t tic avant, In	To Be Co	17. Father's Name (First, Middle, Last) Samuel Bazluke	<u> </u>							(First, Middle, A	Maiden Surnar	пе)	
Mary	and 2 should leath and Men n 27 is marke	-	19a. Informant's Name/Relationship (T Robert Bazluke, s	•							Boute Number,			Code)
Baltimore,	ages 1 are of Heasen of Heam it: If itsm		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 1 □ Donation 5 □ Other (Specify			Place of Dispo cemetery, cren agersto						20c. Location Hagers		wn, State Maryland
Baltii	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or othar once.		21. Signature of Furieral Service Licen:		m) e		Name an				INNICH I Hagerst			E and 21740
ļ	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or		To Car			g, such as	cardiac d	or respiratory arre	est,		Approximate Interval Between Onset and Death 3 weeks
1760,	ate be executed hysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universely that initiated events resulting in death) Last	c	as a consec									
.O. Box 68	The law requires that the death certificat the has been signed by the attending phyoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1 □ Live birt 4 □ Pregnar 9 □ Unknow	h 2 ☐ Feta nt at time of o	al death 3	Ectopic pr Other (sp						ate of deliver	ery Day Year
<u>α</u>	luires that n signed b	by	Part II. Other significant conditions of	ontributing to dea	th but not re	sulting in the u	nderlying c	ause give	en in Part I	,		acco use con es 2 □ No	_	ne cause of death?
Vital Records,		completed									24a. Was a autops perform	y ned?_	Were auto prior to coo death? 1 \(\sum \) Yes	psy findings available mpletion of cause of
Vita	Physician: The this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only on	4		
of	ling Phys	ion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		28b. Time of Injury	-	8c. Injury Work	at		me 5 Reside 28d. Describe ho			y)
Division		Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place o	f Injury - At h , etc. (Spec	nome, farm, str ify)				-	28f. Location (St. City or Town		ber or Rura	d Route Number,
	To the Hospital or within 24 hours afte To the Funaral Dis completely filled in	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the b niner: On the bas and manne	is of examin	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my of	ne, date ar pinion, dea	nd place, ath occurr	and due to the ca	ause(s) and mate and place,	anner as si and due to	tated. the cause(s)
		Me	29b. Signature and title of certifier	7					number	05-		9d. Date signe		
	H-1x1		30. Name and address of person who	TAFF PI	of death (Ite	m 23a) (Type.	Print)	-	500				/22/2	-004
0	H.		NEAR PATALINGHAG, 1	n,0 11110	MEDIC	CAC CAN	PUSI		54/	TE 10	7 HABER	570W M	2	1742
	Sta Regist		31. Date filed (Month, Pay Year) 3 2	004 32.	gistrar's Sign	B. A	reste	)						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7:20 A April 27,2004 Ronald George Cool /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Oeath Examiner Frederick Memorial Hospital Frederick Frederick Frederick

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Yrs. 519-46-6384 Director 1942 California 11, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event. The Medical Exeminer must be notified at 1 ☐ Yes 2 No Director Frederick Knoxville Maryland | the i 10e. Street and Number 10g. Citizen of What Country? ö 530 East Mountain Road 21758 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Vietnam 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: White Specify: δ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) Non Commissioned Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Cool Alyce May Edie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley T. Cool / Wife 530 East Mountain Road Knoxville, Maryland 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State June 10, 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery Arlington, Virginia 21. Sign Ture of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTER STITIAL USUAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of). Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š PULMONARY OBSTRUCTIVE Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred at or Attending F after death. 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D 29a, Certifier 1 🔾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. APRIL, 27 D-57796 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ItOSPITAL , FREDERICIC, MARYLAD MEMORIAL FREDERICK LALIT VERMA 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene 🥎 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2004 **Physician** 22, 7:55 AM Edna Lee Cruze /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
Texas 8. Date of Birth (Month, Day, Year) July 4, 1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🔽 F 87 220-16-5228 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TyPYes 2 □ No Maryland Montgomery Takoma Park Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20912 USA 7912 Lockney Avenue by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2V No Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes XXNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary E. Aston Frank Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7912 Lockney Avenue Takoma Park, Maryland 20912 Arthur D. Cruze/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 25, Pages 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department o Important: If eny injury or once. injury or 2004 Odenton, Maryland W. Arundel Crematory 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licens M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final wan Physician OW disease or condition resulting in death) Due to (or is a consequence of): /Medical **Examiner** Fibrellato Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tranresulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a o 9 Unknown 9 Unknown signed by the Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performe 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director Hospital: 1 X npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Sil 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifies April 22, 2004 D46998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) with ST HYA HOUITE, MD 20782 31. Date filed (Month, Day, Year) distrar's Signature State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #16a&b PER FH C832 6/14/03 JH Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) lay Yea 40 PM **Physician** 22 2004 Apri /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner olumbia trenera EUNT 9. Birthplace (State or Foreign Country)
North Carcline 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, 6. Sex Social Security Number **Funeral** Months Days 1 2 M 2 □ F 16 Yrs. ardina Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State in than "natural", or Items 23a or 28e-f show The Medical Examprer must be obtified at 1 Tes 2 No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 389 Koaa by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Race - American Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Black 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry CONSTRUCTION Elementary/Secondary (0-12) College (1-4or 5+) DEVELOPER other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if tiem 27 is marked oth any injury or other traumatic event gone. Be unknown Dmith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hilwell Rd Baltimore MD 2239 (Name of Date 20c. Location - City or Town, State Sharon Clay/granddaughter 5205 20b. Place of Disposition (Name of 20a. Methodrof Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) -aurel Maryland National Menoral 21. Signature of Fureral Service Licentee 22. Name and Address of Facility llea Millers Metropolitan Chapel 1922 Fores Dr. /tmapolis MD 2140 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) state 016 Cancer INEEK **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy NIA 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown NIA 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 (No 1 ☐ Yes 2 No 1 Yes certificate director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3□ DOA Certification: To To the root within 24 hours after deam.

To the Funeral Director: After th 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) columbia, 5755 cedar lane, Harry Li, M.D. 31. Date filed (Month, Day, Year)
APR 2 8 2004 32. Paistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			1 _ State /	epartment of Health and Mental Hygie Certificate of Death	ne 2004 15007
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physicia	ın	Ronny Hall Combs	April 25	5 2004 11:30A <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Examin	er	Calvert Memorial Hospital	Prince Frederick	Calvert
			5. Social Security Number 6. Sex 7. Age (In yrs. last birth	4. 1 If I ndor 1 Year   If I Inder 24 Hrs   9 Date of Pieth	9. Birthplace (State or Foreign
	Funeral Director			Months Days Hours Min. June 5	1941 West Virgini
			Usual Residence of Decedent		
	yland		10a. State 10b. County 10c. City, Town		10d. Inside City Limits
	Mar.	ģ	Maryland Calvert Pri	nce Frederick	1 □ Yes 2 ☐ No
	r 284	Director	10e. Street and Number		. Citizen of What Country?
	23a C	a D	4905 Sandy Point Road	20678	Jnited States
	deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
ဖွ	after or Ite	교	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2 ☐ Majo Specify:	Specify:
පූ	within 72 hours after death with the Maryland ene. than "natural", or tlems 23a or 28a-f show than Acalcal Exactil et a unit et notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		white
ς. Ο	72 h	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)	b. Kind of Business/Industry
7	vithin ne. han	m d	Flementary/Secondary (0-12) College (1-4or 5+)		Construction
7	filed w Hygie other the		11th Un  17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma	
Ē	be fi	Be	Louis Hall Combs	Vivian See	,
ž	should nd Men marke umatic	<b>1</b> 0		Mailing Address (Street and Number or Rural Route Number, C	City or Town, State, Zip Code)
Maryland 21215-0036	C1 60 75 60		Phyllis Miller Combs- wife 490	05 Sandy Point Road Prince Fi	rederick MD 20678
	1 and Health em 27 ther ti	1	001.01	Discouling (Manager L. Date Co.	c. Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 ☑Burial 2 ☐ Cremation 3 ☑ Removal from State	, crematory or other place) 7 20 2001	er West Virginia
Ħ,	t. Pa rtmer rtant rjury		*4 □Donation 5 □Other (Specify)  21. Signature of Euneral Service Licensee		
Bal	Depa Impo		21. Signature of Editeral Service Licensee	22. Name and Address of Facility Rausch Funeral	Hame
			23a. Part1. Enter the disease, or complications that caused the death. Do no	4405 Broomes Is. rd. Port Republic	MD 20676  Approximate Interval Between
3					Onset and Death
	Pnysician	e y	Immediate Cause (Final disease or condition resulting in death)		
	/Medical Examiner		resulting in death)  Due to (or as a consequence of the control of	"RY ARTERY DIS	SEASE JEARS
н		ē	Sequentially list conditions, if any leading to immediate.  b. Due to (or as a consequence of		
	ed	Jine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	*	
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687	~ ~ <u>~</u>	edic	d		
×	h certificat ending phy use as th	N.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
Вох	eath c atten	Physician/M	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)	Month Day Year
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σ	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as it		Part II Other significant conditions contributing to death but not resulting in		cco use contribute to the cause of death?
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Records	w require been si should i	Completed	Onsulen Dependel	Dirbels Wellilus 24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Re	The law cate has page 2	Ĕ		autopsy performe 1 ☐ Yes 2 ₽	
Vital		Ö	25. Was case referred to medical	26. Place of Death (Check only one)	- 4-
5	Physician: this certific ral director,	0 8	examiner?	patient 3 DOA Other: 4 Nursing Home 5 Residen	ce 6 ☐Other (Specify)
o		n: T	27. Mapor of Death 28a. Date of Injury 28b. T	ime of 28c. Injury at 28d. Describe how njury Work?	injury occurred
Ö	nding I th. r: After e funer	atio	atural 5 Pending (Month, Day rear)	M 1 □ Yes 2 □ No	
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	al or s afte	Certification;	Salaring, etc. (Specify)	· ·	
	e Hospital or At 24 hours after o e Funeral Direc letely filled in by		29a. Certifier 1 Sertifying Physician: To the best of my knowledge (Check only 2 Medical Examiner: On the basis of examination and	, death occurred at the time, date and place, and due to the cau Dor investigation, in my opinion, death occurred at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ledical	one) and manner stated.		
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier M	29c. License number	d. Date signed (Month, Day, Year)
•			Accending thispice	V 1772/	1/ 1/
	d		30. Name and address of person who completes cause of death (Item 23a) (	Type, Print)	m anix
	0		31. Date filed (Month, Day, Year) 32. Registrate Signature	acc in Econ in 1	,_ 00010
	St Regist	ate rar	31. Date filed (Month, Day, Year)  APR 2 7 2004	& South	

# unend item#23a,27,28a-f.PFR MF (832,6/17/0/eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#1state of Manyland / Department of Health and Mantal Hydiana.

n			amend item	State of Mar	vland / Dena	artment of H	lealth and	Mental Hyai	one o o	
			1 - For State Registrar	State of Mai	Cei	rtificate of	Death	Recital Hygit	2004	15008
	Dhunisi.		Decedent's Name (First, Middle, Last	")				2. Date of Death Month		3. Time of Death
	Physici /Medio		Robert Van Downin					April 18	2004	3:12 a M
	Examin	er	4a. Facility Name (If not institution, give		Q	4b. City, Town, o		ath	4c. County of Deat	
	Funeral	_	Southern Maryland 5. Social Security Number 6. Se	x 7. Age (	Center In yrs. last birthday)	Clint If Under 1 Year	If Under 24 H		Prince Geo	orge's  nplace (State or Foreign untry)
	Director		214-69-0324	ØM 2□F	Yrs.	Months Days 28	Hours Mi	Jan. 21,		MD
	and w		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	cation			-	10d. Inside City Limits
	Maryl -f eho	ţō	MD Prince Ge	oorge!s		Unnor	Marlbor	20		1 XYes 2 □ No
	th the or 28a	Director	10e. Street and Number	orge 5		10f. Zip Code	rial iboi		g. Citizen of What Co	untry?
	ath wi	rai	17301 Tanyard Roa				20772		USA	
	ler de	by Funerai	11. Marital Status 1 X Never Married 2  Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
920	urs af	by F	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White
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Maryland 21215-0036	Hygie Hygie other	e Co	17. Father's Name (First, Middle, Last)			Never Wo		ame (First, Middle, Ma	None aiden Sumame)	
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	l and lealth em 27 ther tr		Debra Wyvill/Aunt 20a. Method of Disposition		1254 20b. Place of Dispo	0 Plantat	ion Ct.	Dunkirk,		Farm Chata
000	Pages nent of H int: If ite		1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State	cemetery, crer	natory or other plac			Oc. Location - City or	
Baltimore,			4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Metropoli 22	Name and Address	ss of Facility		exandria,	
ä	permit. Departr Importe any inji		I.C. Won	1	p	0 Box 430		Raymond-Work, MD 207		Home
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused th						Approximate Interval Between
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1	/Medical Examiner		resulting in deality	Due to (or as a c	consequence of):					
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Box	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [		Tatasia annon an			23d. Date of deli	very
O. B	e deat he attr	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at tin		Ectopic pregnancy Other (specify)			Month	Day Year
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O	ding Ih. After funer	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y 4/18/04		Work	vat ⟨? Yes 2.1 <b>€</b> No	28d. Describe how	injury occurred	
Division of	or Attencater death Director: in by the	Certification:	3 ☐ Suicide 6 🗷 Could not be determined		- At home, farm, str			28f. Location (Stre	et and Number or Ru	
ā	ital or A	Cert	Tomodo	residence	Specify)			Prince Go	aird Rd.,Uppe ppe's Colinty	r Marlbono, Mi
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of r ner: On the basis of ex and manner stated	amination and/or inv	occurred at the time restigation, in my op	ne, date and plac pinion, death oc	ce, and due to the caus	s (s) and manner a	stated.
	ro the vithin if	Mec	29b. Signature and title of certifier		1.	29c. License	number	290	I. Date signed (Month	Day, Year)
			- Alla	W/W		0	.C.M.E.	73	pril 19, 2	2004
			30. Name and address of person who co	my ted cause of deat	h (Item 23a) (Type,					
	-0		31. Date filed (Month, Day, Year)	32. Registra	Signature 11	1 Penn St	treet, F	Baltimore,	Maryland 2	21201
	Sta Registr	_	APR 2	2 2004	hour &	Sparte	•			

			For State	State of Man	yland / De		nt of He	alth and M	lental Hyg	_	1101e. 004	15000
	Physicia /Medic	an	Registrar  1. Decedent's Name (First, Middle, Last, Vi	rgil		Dawk			2. Date of Deat Month	h Day	Year 004	3. Time of Death 1:55 A M
>	Examin		4a. Facility Name (If not institution, give Calvert Memori	street and number) al Hospit	al	4b. City Pr	nce	cation of Death Freder	ick		ty of Death alve	rt
	Funeral Director		214 20 4214		In yrs. last birtho 74 Yr	Months		f Under 24 Hrs. Hours Min.	8. Date of Birth A Dr. 2,	Ĭ <b>Ÿ</b> 30	9. Birth Cou Ma	place (State or Foreign ntry) ryland
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336	be filed within 72 hours after death with the Maryland and Hygiene. d other then "naturel", or items 23a or 28a-f show event, the Madical Examinal must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Eve Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S.	13. Was Dec ff Yes, sp		anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	BI	ace - Ameri ack, White afy: B1	
Maryland 21215-0036		Be Completed	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. C		ual Occupations during the second of the sec	on ing most of work	ing	16b. Kind of		ndustry
land	should be filed and Mental Hygis s marked other umatic event, iii	To Be C	17. Father's Name (First, Middle, Last) $Virgil$	I	Dawkin	S	1	8. Mother's Nam Ada	e (First, Middle, I		ame) Iarri	.S
, Mary	and 2 sho lath and N 27 Is ma er treuma	•	19a. fnformant's Name/Relationship (7 Virgil C. Dawki		81	4 Cra	wford	St. (	a/Route Number	11, M	1D 20	745
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other traumatic av <u>once</u> .		20a. Method of Disposition  1 X Buriaf 2 Cremation 3 4 Donation 5 Other (Specify)		20b. Place of Cometery,	Vet.	cother place) Cem.	4/26	/2004		enhan	n, MD
Balt	Departit Departit Importit eny inj		21. Signature of Funeral Service Licens  Mlady G. S	ewell	,	Prin	ce Fr	ederic	well Fu Rd. k, MD 2	06/8	. Hom	
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. PNEUMO Due to (or as a of the	ONIA consequence of BAC consequence of 31TUS	TER III	EMIA	such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death O DAYS  8 DAYS  2 - 3 MONTH
8760,	ate be exe hysician a the burial-	cal	resulting in death) Last	dOue to (or as a	consequence of	n): 						MONTHS
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other (					Date of deliversity	very Day Year
ds, P.	w requires that been signed by should be deta	by	Part fl. Other significant conditions co	ontributing to death but	not resulting in	the underlying	g cause given	in Part I.	23e. Did to	11		the cause of death?
Division of Vital Records,	: The law rec cate has bee page 2 shou	Completed								med? 2 M No	prior to c death?	opsy findings available ompletion of cause of
VIII.	slcian s certif lirector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Innation	2 ER/Out	patient 3 🗍 [	Other		th (Check only or ome 5 ☐ Resid		ther (Spec	ifv)
J Of	ig Phy ter this neral c	on; To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day	28b. Ti		28c. Injury a Work?	it	28d. Describe h	ow injury occ	urred	
Division	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, fari (Specify)	m, street, fact		es 2 No	28f. Location (S City or Tow		nber or Ru	ral Route Number,
	e Hospite 24 hours e Funeral letely filled	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Examone)	ysicien: To the best of iner: On the basis of e and manner state	xamination and	death occurre for investigation	ed at the time on, in my opin	, date and place, nion, death occu	, and due to the c rred at the time, c	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	Bwh -	P	2	29c. License	0 6047		9d. Date sign	ned (Month	
3	3+1		30. Name and address of person who	IMD 100	420H	Type, Print)			PREDA	FICK	MD	20678
	St	ate	31. Date filed (Month, Day, Year)	32. Registra		K A	ast s					

	1	For State Registrar			State of	f Mary	/land /		artmer <i>tificat</i>				1ental		ene 2	004	15010
		Decedent's Name	(First, Midd	le, Last)	-								2. Date of	f Death		Year	3. Time of Death
Physiciar /Medica		MARY A.	DASHP	ER									04		28	04	1:40aM
Examine		4a. Facility Name (If										n of Death				unty of Death	
		Civist								aP.	Lata	er 24 Hrs.	O Data a	4 Dieb		arles	
Funeral		5. Social Security Nu		6. Sex	M 2CLF		n yrs. last b	Yrs.	Months			Min.	8. Date of (Mont) NOV	of Birth 7, Day, 1	Year)	Dela	place (State or Foreign http)
Director	-	222-01-10 Usual Residence of			X	86							IVOV .	1 / 1	917	рета	ware
ow ow	Ì	10a. State	10b. County	/		10	c. City, To	wn or Lo	cation								10d. Inside City Limits
Mary Line	Ö	Maryland	Charl	es		1	Waldo	rf									1 X Yes 2 □ No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examinari, usst be notified at once.	al Director	10e. Street and Num 2719 Lo		rt						603				10	g. Citizen	of What Cou USA	ntry?
death	Funeral	11. Marital Status		12	2. Was Dece	edent Eve	r in U.S.	13. \	Was Dece	dent of I	Hispanic (	Origin? (Sp	ecify Yes o	or No-	14.	Race - Ameri Black, White,	
atter after	7	1 Never Marrie			1 ☐ Yes If Yes, Giv	2 XNo			1 ☐ Yes	•				•	Sp		ite
Shoet 21215-0036 ad within 72 hours alt gjene. or than 'natural', or it, the Medical Exam	d by	3 Widowed			Year or Da	ates:	1 40								Ch Kind		
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d d 2	3	17. Father's Name (	First, Middle	, Last)				500		-1	18. Mo	ther's Nam	e (First, M				
Manual Ma	lo Be	Herman (	. Edw	ards							Cor	a Tho	ompso	n Ed	lward	s	
Maryland 12 should be file h and Mental Hy rie marked oth		19a. Informant's Na Dale S.				ace)	19									wn, State, Zi 20601	
Ce, Lence 1 and 1	-	20a. Method of Disp		SCCII	1 (1410		20b. Place	of Dispo	sition (Na	me of			Date	-		ion - City or T	
Baltimore	- 1	1 □ Burial 2 ] 4 □ Donation	Cremation	3 ⊟Rei Specify)	moval from	State	ietror		natory or Lan C			r 4-29	9-04		Alex	andria	, VA
mit. F		21. Signature of The					10 LU DI							_		1 Serv	
<b>8 9 9 9</b>		XIM	162	le	MOC	0173										MD 20	
Physician		23a Part1. Enter It shock, or heal Immediate Cause ( disease or conditio	t failure. Lis Final	or complicationly one	ations that co cause on e	eaused the each line.	e death. D	o not ent	er the mo	de of dy	ing, such	as cardiac	or respirat	ory arre	st,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)			Due to	(or as a co	onsequenc	e of):									
	ē	Sequentially list confiant, leading to incause. Enter Unde Cause (Disease or	nditions,	b.	Dua to	(or as a co	onsequenc	e of):									
8760, ate be executed hysician and the burial-transit	Examiner	cause. Enter Unde Cause (Disease or that initiated events	riying . injury	<b>1</b>													
O, exect an		resulting in death) l		0	Due to	(or as a co	onsequenc	e of):									
8760, sate be exphysician the burial	ca			d.													
Box 68 eath certifical attending pt for use as it	by Physician/Medical	IF FEMALE:	l neagaant	23	c. If yes, out	tcome of p	pregnancy		**						230	. Date of deliv	/ery
death death death	ciar	in the past 12	months?		4☐Pregr	nant at tim	Fetal death		□Ectopic p □ Other (s		эy 					Month	Day Year
P.O. that the debt by the detached	hys	9 ☐ Unknown	-		9□ Unkn	own							-				
Division of Vital Records, F or Attending Physician: The law requires the after death.  Director: Aller this certificate has been signed in by the funeral director; page 2 should be delined.		Part II. Other signif	icant condit	tions cont	ributing to d	eath but n	not resulting	g in the u	nderlying	cause g	iven in Pa	rt I.		Did tob	٠.		the cause of death? bably 4 Unknown
aw rec	Completed													Was an	2	4b. Were aut	opsy findings available
I Re IThe It The It page ha	E												10	perform	ed?	death?	ompletion of cause of
Vital Fician: The certificate	0	25. Was case refer	red to medic	al							26. Pla	ace of Dea	th (Check		/		
of Vita Physician: this certific	To B	examiner?	No	Ho	spital: 1	Inpatient	2 🗆 ER/	Outpatier	nt 3 🗆 🗅	OA O	ther: 4 🗆	Nursing H	ome 5 🗆	Reside	nce 6	Other (Spec	ify)
On Of ding Phy. After thi funeral		27. Manner of Deat	h 5 🗆 Pend	lina	28a. Date (Mon	of Injury th, Day Y	'ear) 28t	o. Time o Injury		28c. Inju			28d. Desc	ribe ho	w injury o	ccurred	
SiOr tendin eath. for: Af	cati	2 Accident		tigation					М		Yes 2	□No	006 1	(04-		(bas as 0	al Cauta Nimbos
Divi	Certification:	4 Homicide		mined	28e. Place build	of Injury ing, etc. (	- At home, 'Specify)	, tarm, sti	reet, facto	ry, office	•			or Town		rumber or Hui	ral Route Number,
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Atten this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier (Check only one)	1 Certify 2 Medica	ing Physi al Examin	er: On the b	e best of n pasis of ex oner stated	amination	dge, deat and/or in	h occurre	d at the	time, date opinion, d	and place death occur	, and due to	o the ca time, da	use(s) an	d manner as ace, and due	stated. to the cause(s)
To th within to To th comp	Me	29b. Signature and	title of certif	ier /	110	mary surv.			25		se numb			29	d. Date s	igned (Month	, Day, Year)
		) m	MU	Le	we					D-	2103	3 1			4/2	18104	
		30. Name and addr	ess of perso	n who con	npleted cau	se of deat	th (Item 23	a) (Type,	Print)	4 1	T .			T7 -	,	C 34T	20622
066		Michael							/ 0 0	Τđ	Line	Cen	ter	wal	dor	r, MD	20602
Stat Registra		31. Date filed (Mon	APR 3	0 20	04 32. F		Signature		have								

#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dey 73 Am 4b. City, Town, or Location of Deeth R 26 100S 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) HAGERS LOWN If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Yeer) NOV. 27, 1 JULIA MANOR HEALTH CARE CENTER WASHINGTON If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months Days 1 M 2 F Yrs 92 287-09-0864 OHIO Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 □ No HAGERSTOWN MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 333 MILL STREET 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: 3 XWidowed 4 ☐ Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOME ECONOMIST POWER AND LIGHT CO. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) EDITH MAE GARRETT SMILEY RICHARD RAWLINS 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 5423 Porterstown Road, Keedysville, MD 21756 ROBERT W. EDWARDS, JR, SON 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORY 4/27/04 SMITHSBURG, MARYLAND 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME 21713 BOONSBORO, MARYLAND A.) Zimmerman 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailore. List only one cause on each line. Approximete Interval Between Onset and Death Denmatitis Immediate Cause (Final diseese or condition resulting in death) Bullous Hypertensio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other (Specify, ccurred

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requiras that the death certificate be assocuted within 24 hours efter death.

To the Funeral Director: After this cartificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be datached for use as the buriel-transit Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

**Physician** 

/Medical

Examiner

**Funeral Director** 

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Completed

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**Funeral** 

Director

permit. Pegas 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mental Hygiena. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event measure.

Baltimore, Maryland 21215-0020

resoning in deathly 2001	l d				
Part II. Other aignificant conditions	contributing to death but n	ot resulting in the un	derfying caus	se given in Part I.	23b. Did tobacco uso
					24a. Was an autopsy performed?
25. Was case referred to medical				26. Place of	Death (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursin	ig Home 5 ☐ Residence 6 ☐
27. Manner of Deeth	28a. Date of Injury (Month, Dey Yo	28b. Time of Injury	28c	Injury et Work?	28d. Describe how injury o

1 Tes 2 No investigetion 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

00060396

26/04

1// Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

ARID MUMSHED

State Registrar 31. Date filed (Month, Pay Year). 32. Pegistrer's Signature

			For State Registrar		State of Ma	ryland /		rtment of F		l Menta	l Hygier	20	n I.	1501	•
			Registrar     Decedent's Name (Firs	st, Middle, Last	)			mouto or	Dodin	2. Dat	e of Death	No. 2 ()		3. Time of Death	€.
	Physicia /Medic		VIRGINIA		H.		FE	deRL 4b. City, Town, o	ر الاستان الدين الم	ap	Rib ?	11/	04 Death	0345 am	1
	Examin	er	4a. Fecility Name (If not in	S HOPK	INS HOS	pita	4	BAltir	MORE	City	/	1	IONI		
	Funeral Director		5. Social Security Numbe 214 12 048	1 1	TM 2FTF	(in yrs. last i	Yrs.	Months Days	Hours Mi	rs. 8. Dat in. (Mo	e of Birth in <i>th, Day,</i> Ye	er) 1919		lace (State or Foreign try) cvland	л
	ow at		Usual Residence of Dece			10c. City, To	wn or Loc	ation		-				0d. Inside City Limits	
	Many m-f sh	ctor	MD H	Ioward		El	lico	tt Cit	У					1 ☐ Yes 2 🔀 No	)
	or 28	Director	10e. Street and Number			_		10f. Zip Code	_			Citizen of Wh			
	s 23a	rai	3258 Norma	andy W	OODS Dri			2104		(Specify Vo		nited			_
936	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notilied at	by Funerai	11. Marital Status 1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ □		Armed Forces?  1  Yes  2 N  If Yes, Give  Year or Dates:		lf lf	Yes, specify Cub	an, Mexican, Pu	erto Rican,	etc.)		White,		
20	72 hor	eted		Decedent's Edu		16	(Give k	ent's Usual Occup	during most of w	vorking	16b	Kind of Busi	ness/ind	lustry	
21215-0036	within 7 lene. then r	Completed by	Elementary/Secondary		College (1-4or 5	+)	life. D	O NOT use retire	d)			2-4-37	1		
	filed w Hygier other ti		12 17. Father's Name (First,	Middle, Last)			Audi	tor	18. Mother's N	lame (First,		Retai] den <i>Sumame</i> )			_
ano	Mentat Mentat arked o	To Be	Charles Hi		У				Halli	e Rur	kles				
Maryland	E B E E	۲	19a. Informant's Name/F	Relationship (T)	/pe, Print)	1	9b. Mailing	Address (Street	and Number or	Rural Route	Number, Ci	ty or Town, St	ate, Zip	Code)	
	s 1 and 2. If Health ar Item 27 is		Barbara M.	Mill	er/Daugh			Gilli	s Road						
Baltimore,	permit. Pages 1 am Department of Heal Important: If Item 2 any injury or other ance.		20a. Method of Disposition  1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	mation 3 DF		ceme	tery, crem pect	ition (Name of atory or other pla Cemet	ery 4-		004 M	Location - Ci	ry,	MD	
Balt	permit. Departitimports any inj	) ( ))	21. Signature of Funeral	allus	Will C		41	12 Old	Colum	bia_F	Pike I	itzke' Ellico	s E		H
			23a. Pert1. Enter the dis shock, or heart failu	ease, or comp ure. List only o	lications that caused ne cause on eech lir	the death. D	o not ente	r the mode of dyn	ng, such as card	iac or respi	ratory arrest,			Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_	,5EPS	15							ć	24 hours	ź
	/Medical Examiner		resulting at deathly		Due to (or as	/	e of):							48 hour	26
		er	Sequentially list condition if any, leading to immedi	ate	b. Due to (or as	a consequence							- 0	TONOUR	با
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	CONCE	stive	He	PRI:	ailur	38				7 days	ì
Ő,	cate be executed physician and the burial-transit		resulting in death) Last		Due or as	a consequenc	e of):						- 17	1	
8760,	cate b	dicai			d										
9	eath certific attending p	/Me	IF FEMALE:		23c. If yes, outcome	of pregnancy						23d. Date	of delive	irv	
P.O. Box	the d y the	Physician/Me	23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 No 9 ☐ Unknown	mani he?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel dea		Ectopic pregnanc Other (specify) _	У			Month		Day Year	
	Se ig	by	Part II. Other significant	conditions co	ntributing to death b	ut not resulting	g in the un	derlying cause gi	ven in Part I.	23	e. Did tobace	V/	ute to th	ne cause of death? ably 4 □Unknowr	1
Records,	9 4 9	ompleted								-	a. Was an autopsy performed	r? de	ere autor or to con ath? ] Yes	psy findings available appletion of cause of 2 No	9
of Vital	sician: Th certificate irector, pag	BeC	25. Was case referred to examiner?					T.	26. Place of C	Death (Chec	k only one)				
) (	this at dir	P	1 ☐ Yes 2 No		Hospital:		Outpatient	3 DOV		-		6 ☐Other		)	
nc	ing After	ion:		Pending	28a. Date of Inju (Month, Day	y Year)	njury	28c. Inju Wo M 1	ryat rk? ]Yes 2∐No	280. De	escribe now i	njury occurred	1		
Division	ten leal tor: the	Certification:	2 Accident 3 Suicide 6 [ 4 Homicide	investigation Could not be determined	28e. Place of Injuding, etc	ury - At home, c. (Specify)	farm, stre	eet, factory, office	, 103 2 2 110		cation (Stree y or Town, S		or Rura	l Route Number,	
_	spita hours meral	Medical C			rsician: To the best	examination									
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title	of certifier				29c. Licens	se number		29d.	Date signed (	Month, i	Dey, Year)	
			7	SON A.	WELLEAN	S. M.A		RE	5-00	0C	ar	DRIL	24	t, 2004	
	5/ d	6	30 me and address o				a) (Type, F	Print)			10.1	n	K 17 11	7	
	-02		JASON A.		125 600	N. WC	311	STREE	+ BAI	HIMO	RE, M	D 210	28"		
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2004 **Physician** FREDRICKSEN 9:05p.M RUTH ANNA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON BOONSBORO REEDERS MEMORIAL HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | APRIL | 12 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Year) **Funeral** 1 □ M 2 X F Yrs. 1916 318-20-1445 ILLÍNOIS 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28e-f show other traumatic event, the Modical Examiner must be notified at 1X Yes 2 □ No BOONSBORO MARYLAND WASHINGTON Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or U.S.A. 21713 141 S. MAIN STREET Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or item any injury or other traumatic event, the Modical Exemples 2008. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3X Widowed 4 □ Divorced WHITE Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PART MANUFACTURER SHIPPING CLERK 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARGARET ANNA RHINE HUGO FRED PETTER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KAREN TALBOT, GRANDDAUGHTER 410 MT. HOPE ROAD, FAIRFIELD, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY 4/23/2004 SMITHSBURG, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND Zimmerman Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) meleclalie center alles and a /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year detached for 5 Other (specify) 4☐Pregnant at time of death Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 ☐ Probably 4 ☐Unknown 1 Yes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 No Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after deat e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 032518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keedysville, M.D. 21756 / 301-432-2225 Robert Guedenet 21Wyand Dr. 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F			iene20	14 15014
	Physici /Medic		1. Decedent's Name (First, Middle, La.	D.	Fugitt,	SR.		2. Date of Deal Month	th _	Year 10:04 pm
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	Funeral Director		579–10–7034	ØX 7. AG	e (In yrs. last birthday 83 Yrs.	Months Days	Hours Min.		Year)	9. Birthplace (State or Foreign Country) Maryland
	land wo		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary Ff sh	ţō	Maryland Anne A	rundel		Annapo	lic			1 ☐ Yes 2 💆 No
	or 288	Director	10e. Street and Number			10f. Zip Code	110	1	0g. Citizen of Wh	nat Country?
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36	ges 1 and 2 should be illed within 72 hours after death with the Maryland it of Health and Mentai Hygiene.  If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, if a Madical Examination to the return to a second of the majoral Examination.	by Funeral	11. Marital Status  1 □ Never Married 2XXMarried  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ₩00	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		American Indian, White, etc. White
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Baltimore,	permit. Pages 1 and Department of Heal important: If item 2 eny injury or other ance.		1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	matory or other plac	, I			
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m	Depa Impo eny ii		> (White duce		2	2973 Solon	nons Isla	and Rd. E	dgewater	, MD 21037
8760,	Physician I/Medical Examiner transit sthe purial-transit	dical Examiner	23a. Part1. Enter the disease, or companies to the shock or heart failure. List only of the shock of the shoc	a. AdM of Due to (or as b. Due to (or as c.	a consequence of):  a consequence of):					Interval Between Onset and Death
P.O. Box 68	t the death certif by the attending ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date o	
	w requires that been signed I should be det	by	Part II. Other significant conditions of	entributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.			te to the cause of death?
al Records,	: The law requirate has been page 2 should	Completed						24a. Was an autopsy perform	prio dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
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Divisi	To the Hospital or Attending Physician: within 24 hours after death: To the Funeral Director: After this certified completely filled in by the funeral director; g	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, farm, str . (Specify)		05 2	28f. Location (Str. City or Town,	eet and Number o State)	or Rural Route Number,
	he Hospitt n 24 hours he Funera pletely fille	Medical C	29a. Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of inar: On the basis of and manner sta	f my knowledge, deatl examination and/or in ted.	n occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and manne te and place, and	er as stated. due to the cause(s)
	To t withi To tl	Σ	29b. Signature and title of certifier	412		29c. License	number	29	d. Date signed (A	fonth, Day, Year)
			I le Comme	· IVID		Dol	05917	3	4-29-	04
			30. Name and address of person who co Kathleen Kemr	ompleted cause of de	path (Item 23a) (Type,  OBCS + GCT r's Signature	Print) te Rd, #	300, An	napolis,	MD 2	1401
	Sta Registra	te ar	31. Date filed (Month, Day, Yar) 2	32. Agistra	r's Signature		,			

State of Maryland / Department of Health and Mental Hygiene 200415015 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 28, 10:20 PM Dorothy L. Gladmon 2004 April /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel Edgewater Millennium at South River If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F 9-5-1924 Washington, DC Director 578-22-5651 Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ? is marked other than "neturel", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Maryland Edgewater Anne Arundel Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21037 USA 1501 Warfield Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "neturer", or Item any injury or other traumatic event, the Medical SDES. 1 Never Married 2 Married Yes 2000 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give Year or Dates: Completed by 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HUD-Federal Government Office Manager 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry S. Duvall Esther I. Bean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1501 Warfield Rd., Edgewater, MD 21037 Hewitt W. Maus, Jr./Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 5-3-04 Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final month Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 100 1 Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 this certificate 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) After t 27. Manner of Death 28c. Injury at Work? or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1238563 ) anda 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anonsville Red Bier 134 baum und Wayne D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar		State of M	arylan		artmen rtificat					Reg. No	Z 11 11 2	150	16
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			State of Maryland / Department of Heal  1- State Registrar Certificate of Dec	alth and Men		ene 2004	15017
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic	al	RUTH LENORA HENDERSON  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local	cation of Death	buil 5	4c. County of Death	1240 PM
	LXdIIIII	e.		ERSTOWN		WA	SHINGTON
	Funeral Director			lours Min. (	Date of Birth (Month, Day, Y		place (State or Foreign intry)
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or Items 23e or 28e-f show entry injury or other treumetic event. I'm Medical Erain, at must be rediffed at once.	tor	MARYLAND WASHINGTON HAGERS	STOWN			10d. Inside City Limits 1 X Yes 2 □ No
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E C	Pages nent of int: If It ury or o		1 ▼ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Cemetery, crematory or other place)  BOONSBORO CEMETERY	APR. 26.		BOONSBORO,	
Baltimore,	permit. Departm Importe eny inju		21. Signature of uneral Service Library 22. Name and Address of	Facility	7606 0	LD NATIONA	L PIKE
	40500		RELIVA, ZIMMERMAN  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying and		-	ORO, MARYL	Approximate
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Records,	aw requir ts been si 2 should	Completed			24a. Was an	24b. Were auto	posy findings available
	The lay	Com			autopsy performe 1 Yes 2 €	d? prior to co death? 1No 1 ☐ Yes	mpletion of cause of 2 No
Vita	ysicien: The is certificate hidirector, page	Be	examiner? Hospital: Other	. Place of Death (Ch			
J Of	유무교	n: To	27. Manne eath 28a. Date of Injury 28b. Time of 28c. Injury at			be 6 Other (Special injury occurred	fy)
Division	Attending I er death. rector: After by the funer	catio	2 Accident investigation M 1 Yes				
Σ	after of Direct Direct Direct din by	Certification:	determined  4 Homicide  determined  determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. I	Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my knowledge, death occurred at the time, da 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinior and manner stated.	late and place, and on, death occurred at	due to the caus t the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	To the To the Complex	Me	29b. Signature and title of certifies 29c. License num	mber	29d.	. Date signed (Month,	Day, Year)
	2		►SAMUEL CHAN, MD 03665	> >	Ap	nl 23	; 2004
1	st!		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  3 LY Elast Anticetan Stweet Suite 200; High	STOWN.	mo 3	nl 23.	
	Sta Registr		31. Date filed (Month, Day, Year).  APR 27 2004  32. Registrar's Signature  APR 27 2004  APR 27 2004				

		1	For State Registrar	State of Ma	arylan	-		nt of He te of D		ind M	-	giene Reg. No.	2001		5018
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Las	n Hav	201						2. Date of De	ath Day	Year 4 04	030	e of Death
7 7	Examin Funeral Director	er	184-60-8280	Marylan	(In yrs. 1	ledus (Cerast birthday) Yrs.	th	Town, or B	Location of Literal Industry Hours	more	8. Date of Bir	<u> </u>	County of Deat	hplece (Sta	te or Foreign
	Maryland -f ahow		Usual Residence of Decedent  10a. State 10b. County PA. Fulton			, Town or Lo		3							e City Limits ∕es 2√2 No
	with the a or 28e	Funeral Director	10e. Street and Number •	ane				p Code 17233				10g. Cit	izen of What Co	ountry?	
920	hours after death tural', or Items 23 a Examinat must	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 Yes 25 If Yes, Give Year or Dates:		1	Was Dece If Yes, spo 1  Yes		spanic Origin, Mexican Specify:	gin? (Spe . Puerto f	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whil SpecWhit	e, etc.	1,
21215-0036	l within 72 iene. r then "ne the Medic	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		i+)	16a. Dece (Give life.	kind of w	ual Occupa ork done di use retired)	urina most	of workir	ng	16b. Ki	ind of Business	Industry	
Maryland 2	be file ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last)  John E. Hann	0		105 11-35			Hele	en		ttma:	= 3/1/	Zin Codo)	
	1 and 2 s Health ar em 27 is ther trau		19a. Informant's Name/Relationship (1 He1en D. Hann/ N  20a. Melhod of Disposition 1 ∰Burial 2 □ Cremation 3 □	Nother	C	182 H	lawks	Hill me of other place	Lane	e, Mc	Connel	Lsbur 20c. Lo	rg, Pa	! 7233 Town, State	
Baltimore,	permit. Pages Department of I Important: If It any injury or o		4 Donation 5 Other (Specify 21. Signature of Runeral Service Licen	)	1011	ion Ce		nd Address	s of Facility	1/27/ 103 Trade		P1.	nnelsbu Hagers		Md.21740
8760,	The law requires that the death certificate be executed  XA  A  A  A  A  A  A  A  A  A  A  A  A	dicai Examiner	23a. Pert1. Enter the disease, or composition, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or a)	tage a consequence a consequence ulo	uence of):  uence of):  patt		de of dying			r respiratory a	rrest,		Approximation interval onset a 3+	Male Between and Death
P.O. Box 68	it the death certifica by the attending pt tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	I death 3[	⊒Ectopic (						23d. Date of de Month	ivery Day	Year
	w requires that the second of	þ	Part II. Other significant conditions o	ontributing to death b	ut not res	ulting in the u	underlying	cause give	n in Part I.	,		obacco ( Yes 2	use contribute to		of death?
Vital Records,		Completed									1□ Yes	psy med? 2 1 No	deeth?	completion	ngs available of cause of
n of Vit	ng Ph Itter th Ineral	on: To Be	25. Was case referred to medical examiner?  1 Yes 2 1 100  27. Manner of Death  1 1 2 1111	Hospital: 1 Impation 28a. Date of Inju (Month, Da		ER/Outpatie	of	28c. Injury Work	at ?	rsing Hor	(Check only only one 5 ☐ Resi	dence	6 □Other (Spe	cify)	
Division of	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fa	Certification:	2 Accident 3 Suicide 6 Could not b 4 Homicide determined		ury - Al ho c. (Specif	ome, farm, st	M treet, facto		/es 2 □ I		28f. Location ( City or To		nd Number or Ri	ural Route f	√umber,
	he Hospit in 24 hours he Funera pletely fille	Medical (	29a. Certifying Ph (Check only one)	ysician: To the best niner: On the basis o and manner st	f examina	wledge, dea tion and/or in	nvestigatio	on, in my op	oinion, dea	d place, a	and due to the ed at the time,	date and	d place, and due	to the cau	
	To t To t	M	29b. Signature and title of certifier	m	MD			9c. License	number				te signed (Mont 4/04	h, Day, Yea	r)
6	410		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type - NZ - Pr	. Print)	16 Balz	l imta	MO	21230	>			
	St: Regist	ate rar	31. Date filed (Month Op (Year) 6	2004 32. Registr	ars Signa	H. L	fourte	1							

		1 - For State Registrar AMEND TIEM #29	State of Maryland / Dep. d PER PHY C831 5/11/64	artment of Health and M	ental Hygien	ne 3.0.0 i
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Robert Et  4a. Facility Name (If not institution, give s  11805 Crestwood	treet and number)	n, Sr.  4b. City, Town, or Location of Death Brandywine	April 12	3. Time of Death 2, 2004 3:15AM  C. County of Deeth  Prince George's
Funeral Director		5. Social Security Number 6. Sex 243-16-7160 The Usual Residence of Decedent	M 2□F 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan. 23, 1	9. Birthplece (State or Foreig Country) 1922 North Carolina
n the Marylan r 28a-f show I nutified at	Director	Maryland Prince Geo		Brandywine	10g. C	10d. Inside City Limit 1 ☐ Yes 2☐N  Citizen of What Country?
i / z nours anter deam with the maryland "naturel", or items 23a or 28a-f show calcal Extraitmentat be notified at	by Funeral D	1 ☐ Never Married AMMarried	2. Was Decedent Ever in U.S. Armed Forces 1 Types 2 PNo 1941   If Yes, Give	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: 1.75-2-0
within 9ne. than	Completed b	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12) 12th	Completed) (Give life.	A  den's Usual Occupation kind of work done during most of workir DO NOT use retired)  Force Retired	99	White Kind of Business/Industry  S. Government
tal Hyg	To Be Co	17. Father's Name (First, Middle, Last)  Thomas Jefferson  19a. Informant's Name/Relationship (Typ.	n Harmon		(First, Middle, Maide Pad g	on Sumame) Bett
of Health a of Health a fitem 27 la		Robert E. Harmon,  20a. Method of Disposition  1 Typurial 2 Cremation 3 CRe	Jr. (Son) 261	O Midway Branch Dr	. Apt 102	
permit. Prages Department of Important: if it any injury or o		4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License	Maryland	Veterans Cemetery	2004 Chu E Funeral	Home, Inc.
hysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulling in death)	callors that caused the death. Do not entered advise on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
e attending physician and to rose as the burial-transit.	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
ed by the attending physidetached for use as the b	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
been signed by the should be detache		Part II. Other significant conditions conf	ributing to death but not resulting in the u	nderfying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ate has b	e Completed	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification; To B	examiner?	ospital: 1 Inpatient 2 ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	f 28c. Injury at 24 Work? M 1 □ Yes 2 □ No	e 5 esidence 8d. Des ribe how inju	
24 hours after d • Funeral Direct letely filled in by		4 Homicide determined  29a. Certifier #Certifying Physic	28e. Place of Injury - At home, farm, str building, elc. (Specify) cian: To the best of my knowledge, death	n occurred at the time, date and place, ar	City or Town, Stat	s) and manner as stated.
within 24 To the Fu	Medical	(Check only 2 Medical Exeminone)  29b. Signature and title of certifier	er: On the basis of examination and/or invand manner stated.	29c. License number		ate signed (Month, Day, Year)  4/12/04
الخا		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type,	Print) Krishan Math	or M.D.	/
Sta Registra	_	31. Date filed (Month, Day, Year) APR 1 3 20	32. Redistrar's Signature	Carles	<u> </u>	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Burton D. Hazel, Sr. 6:00 AM Apri1 24 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's 8. Date of Birth (Month, Day, May 4 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2 F 321-24-8516 83 Director 1920 Canada Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show rictified at 1 Yes 2 No Director Maryland Anne Arundel Edgewater the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a or 2 41 Clairborne Road 21037 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Per 2 No If Yes, Give or Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married The Medical Evanuit Baltimore, Maryland 21215-0036 Specify: white by. 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: WWII 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) superintendent construction other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental H ent: If item 27 is marked of Joseph Hazel Mary Cronin ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Hazel / wife 41 Clairborne Rd. Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State rtment of I rtent: If it njury or o Importent: It any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 4. 4-28-04 Baltimore, MD Departing. 21. Signature of Funeral Service License John M. Taylor Funeral Home, Inc. Wmus 147 Duke of Gloucester St. Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician DMEN resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physiciar Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I Yes 2 No detached the 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe q PARKINSON'S DISEASE nisorper. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed page 2 should peen CEPTERROVASCULAR DISEASE, DIABETES MELLITUS II, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate HEMOCHROMATOSIS, ANEMIA CATARACTS 1 Yes 2 No ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 I EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No the f 2 Accident 6 Could not be determined 3 Suicide 4 Homicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 0 Hospitel filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier To the 29c. License number 29b. Signature and title of certifier D 50963 of death (Item 23a) (Type, Print) CHVH, CHARLOTTE HALL, MD 31. Date filed (Mont) State

DHMH 17 Rev 1/2001

Registrar

		partment of Health and Mental Hygiene ertificate of Death Reg. No. 2004 1502
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  Laura Hummel  4a. Facility Name (If not institution, give street and number)  Genesis Eldercare	2. Date of Death Month Day Year 23, 2004 7:45a Mark Severna Park April Anne Arundel
Funeral Director	5. Social Security Number  169–18–7303  6. Sex 1 M 2 XF 89 Yrs  Usual Residence of Decedent	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Emportant: If them 27 is marked other than "natural", or flams 23e or 28e-f show any injury or other treumatic event, the Model Examination and once.  To Be Completed by Funeral Director	10e. Street and Number  24 Truckhouse Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  12  17. Father's Name (First, Middle, Last)  Samuel Magroski  19a. Informant's Name/Relationship (Type, Print)  Lucille Henault/Daughter  20a. Method of Disposition  1 Signal Supposition  1 Signal 2 Cremation 3 Removal from State	Tot. Inside City Limits  The Park  Tot. Zip Code  Tot. Zip Code
ding Physician: The law requires that the death certificate be executed the highest that the death certificate has been signed by the attending physician and teneral director, page 2 should be detached for use as the burial-transit or provident to the completed by Physician/Medical Examiner	JF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 3 Probably 4 Obertone to completion of cause of death?  25d. Place of Death (Check only one)  26d. Place of Death (Check only one)  27d. Date of delivery Month Day Year
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: Attencompletely filled in by the funeral Medical Certification:	(Check only 2   Medical Examiner: On the basis of examination and/or one) and manner stated.	City or Town, State)  ath occurred at the time, date and place, and due to the cause(s) and manner as stated.  investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
State Registrar	30. Name and address of berson who completed cause of death (Item 23a) (Typ  31. Date filed (Month, Day, Year)  APR 2 8 2004  32. Figistrar's Signature	29c. License number 29d. Date signed (Month, Day, Year)  D57531  PPRIL 23 2004  a, Print)  My Millergune no 21108

				epartment of Health and M		0001
	Physic	ian	1 - State Registrar AMEND TIEM #23c PER PHY G831 5/10/04  1. Decedent's Name (First, Middle, Last)	CMINCALE OF DEALIT	2. Date of Death	No. 2 1 5 2 2  Day Year 3. Time of Death
Žį.	/Medi Exami	cal	EARL HAGGINS  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	64	4c. County of Death
	LAdiiii	iei	Howard County General Hospital	Columbia	I.	Howard
	Funeral Director		5. Social Security Number  579–42–1106  Usual Residence of Decedent  5. Sex   7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Dey, Ye MAR 12 19	BY - 17 00 - 1
	the Maryland 28a-f ehow	Director	10a. State 10b. County 10c. City, Town o	2011	140	10d. Inside City Limits  X☐ Yes 2☐ No
	h with 23a or	al Dir	10e. Street and Number Cherry Lane Nursing Ct. 9001 Cherry Lane	10f. Zip Code 20708	10g.	Citizen of What Country? USA
920	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It am Ameria Hygiene. It is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinational the molified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Marned 1 Never 2 (7No	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	in 72 ha "natu edical	Completed	(Specify only highest grade completed) (G	ocedent's Usual Occupation ive kind of work done during most of working. b. DO NOT use retired)	ng 16b	. Kind of Business/Industry
212	filed withi Hygiene. other than	Com	Elementary/Secondary (U-12)   College (1-4or 5+)	autician		elath
Maryland	should be fit and Mental H marked oth umatic even	To Be		Matilda	(First, Middle, Maid Haggins	
	nd 2 sho alth and 27 is m			alling Address (Street and Number or Rural 1 Lakewood Place Wal		
Baltimore,	Pages 1 and 3 nent of Health int: if Item 27 iry or other tra		20a. Method of Disposition 1 ☐ Burial, 2 XX Cremation 3 ☐ Removal from State  20b. Place of Discemetery, 6	A CONTRACTOR OF THE PARTY OF TH	ate 20c.	Location - City or Town, State exandria, VA
Balti	permit. Pag Deportment Important: I any injury o once.		21. Signature of Funeral Service Licensee M00173		rwein Fun	eral Srrvices
2	Pnysician /Medical		23a. Payl. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	enter the mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between Onset and Death
8760,	death certificate be executed to a stending physician and dror use as the burial-transit	dical Examiner		COMIAL PNEU	MONI	A wearly
Box 6		Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
۵.	luires that the signed by aid be detacted	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Vital Records,	The law requires that the sate has been signed by the page 2 should be detached.	Completed	Stage IV presidente Acute Renal fail	re	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	(Q) LL	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	No 1
of	y Physics of this control of the direction of the directi	. To	1 ☐ Yes 2 ☐ No ☐ Hospital: ☐ Inpatient 2 ☐ ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time	The state of the s	ne 5 Residence 8d. Describe how inj	6 ☐Other (Specify)
Division of	To the Hospital or Attending Physician: In thin 24 hours after death or the Funeral Director; After this certific completely filled in by the funeral director,	Certification:	Natural 5 Pending (Month, Day Year) Injury    Accident investigation   3 Suicide   6 Could not be determined   28e. Place of Injury At home, farm.	M 1 Yes 2 No	8f. Location (Street a	and Number or Rural Route Number,
Ö	oital or A urs after ral Directed in by		building, etc. (Specify)		City of Town, Sta	ite)
	To the Hospital or within 24 hours afte To the Funeral Dire completely filled in the	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	nd due to the cause( d at the time, date a	(s) and manner as stated.  nd place, and due to the cause(s)
•	To To Com	×	29b. Signature and title of certifier  RTelliery Attending M	29c. License number 0 50303		Pate signed (Month, Dey, Year)
1	33		30. Name and address of person who completed cause of death (Item 23a) (Typ RODOLFO FOR INVOCE 405 FYE	e. Print) Herrou Rd Ste 162	2 Catons	ulle, MO21228
	Sta	te	31. Date filed (Month, Day, Year) 32. 5 gistrar's Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7:30pM Mary Frances Higgins 18, Apri1 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Clear Spring
If Under 1 Year | If Under 24 Hrs. 14924 National Pike Washington 8. Date of Birth
(Month, Day, Year)
June 26,1932 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1□M 2\ F 71 Yrs Director 218-30-7787 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "naturel", or ttems 23s or 28s-f show event, the Medical Exeminer must be notified at 1 Yes 2 No MD Washington Clear Spring Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21722 14924 National Pike U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturet", or Item any injury or other traumatic event, Ital Medical Exercised pages. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 【No 3altimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Wife / Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Kratz Ellen Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14924 National Pike Clear Spring, Md 21722 Lewis Higgins (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Smithsburg Crematory 4/20/04smithsburg, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md 21783 Pirit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebral Vascular Accident **Physician** weeks /Medical Examiner Necrotic 4th and 5th Right weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physicien and for use as the burial-transit ears Hypertension
Due to (of as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 🗌 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No page certificate 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number and title of certifier 29d. Date signed (Month, Day, Year) MD0052136 20/04 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Williamsport Family Practice 3 Byrkit Dr. Williamsport MD 21795 iccarelli 32. Registrar's Signature 31. Date filed (Month, Day State Registrar

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alti	permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service License	1/	6	sborne	Adpres	nerally	Hom	ne, P.A.	LILIGNA	por i	mar y rang
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Division	or Atten iffer deat Director: In by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)			03 2 310	-	28f. Location (Str. City or Town,	eet and Numb State)	er or Aural	i Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my er: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	th occurred at ovestigation, in	the time	e, date and inion, death	place.	and due to the car ed at the time, da	use(s) and ma te and place,	anner as sta and due to	ated. the cause(s)
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2	JH- "		STEPHEN E-M	ripleted cause of death	(a)	Print)	Von	THER	NH	he !	HOGO	STOU	in las
	Sta Registi		31. Date filed (Month APR 23 20	32. Régistrars s	Signature . A.	nek						5/7	147

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Der MD State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#26,4/28/04,fchd,SL Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Grace Souder King April 26. 2004 12:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26110 Ridge Road Damascus Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Yrs. Director 577-10-7432 90 July 23, 1913 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Damascus Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26110 Ridge Road Completed by Funeral 20872 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
sin: If item 27 is marked other than \*natural; or Itams 23.
ury or other fraumatic avent, the Wedfrell Earth or manner. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 27 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Circuit Court of Elementary/Secondary (0-12) College (1-4or 5+) Maryland Executive Assistant Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Archie Souder Sallie Purdum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 Daniel C. King - Son 26421 Mullinix Mill Road, Mount Airy, Maryland
20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ABurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny Injury or once. Injury or Damascus Meth. Cemetery 5/1/04 Damascus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee, 22. Name and Address of Facility Olin I. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland shock, or heart failure. List only one cause on each line. 20872-0117 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): -Mantle Cell disease or condition resulting in death) Lymphoma Months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed signed by the attending physician and does detached for use as the burial-tran use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy certificate 20 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Const (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending Injury after death.

I Director: Aff investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MDO 60335 Barren

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State

Registrar

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registral's Signature Drive

			State of Ma				Health and N	Aental Hydi	ana	
	-	For State Registrar			Cer	tificate of	Death	Re	g. No. 200	4 15026
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/Medica		Clara Robinson Kay				4h City Tours	or Location of Death	April 18 2	4c. County of D	4:30 A M
Examine	r	4a. Facility Name (If not institution, give st Sunrise of Annapolis	reet and number)			Annapolis	Location of Death		Anne Arun	
Funeral Director	- 1	5. Social Security Number 6. Sex	7. Age	(In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 14 19	9. 118 M	Birthplece (State or Foreign Country) Paryland
yland		Usual Residence of Decedent  10a. State  Maryland  10b. County  Anne Arundel		10c. City,	Town or Lo	cation				10d. Inside City Limits
ith the Marylar or 28a-f ehow	Director	Paryland Part Product								1X Yes 2 No
3a or 24	al Dire	10e. Street and Number 800 Bestgate Road				10f. Zip Code 21401		10	g. Citizen of What United S	
death	Funeral	11. Marital Status	2. Was Decedent E Armed Forces?	ver in U.S	. 13.	Was Decedent of h	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		American Indian, Vhite, etc.
tiled within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or Items 23e or 28e-1 show ont, the Madical Examiner must be notified at	ବ	1 ☐ Never Married 2 ☐ Married  X☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	lo		1 □ Yes 2 1 No	Specify:		Specify: W	hite
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d 2 shouth and M ris mar traumat		19a. Informant's Name/Relationship (Type John E. Robinson – son					and Number or Rui			re, Zip Code)
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Defilitions, We permit. Pages 1 and 2 Department of Health & Important: If item 27 is eny injury or other tra		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)		Solan		natory or other pla etery Apri		<b>S</b> 0.	larans Mary	yland 
permit. Depart Import		21. Signature of Funeral Service License	2000	>-	1	. Name and Addre	Ra	usch Funera		0676
No. of the last of		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused	the death.	Do not ent	er the mode of dyi	s Rd Port	or respiratory arre	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	alm		mes	Dar	ientia			Onset and Death
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the de	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	time of de	am 5_					
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VIIAI NEC sician: The law s certificate has b lirector, page 2 s									1U	Yes 2□ No
Or VILA Physician: riths certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:	nt 2□F	R/Outpatier	nt 3 DOA Ot	hor	th (Check only one ome 5 ☐ Reside	T V MINO	Specify) PS S
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To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	Medical Co	29a. Certifier Check only 2 Medical Examin	er: On the basis of	examinati						
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner sta	///	11	29c Licen	se number 55	29	d. Date signed (M	Ionth, Day, Year)
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3	-	30. Name and address of person who co	on	D	8600	)   Vetan	ons Hr	hury # &	204 11	2110
Star Registra		31. Date filed (Month, Day, Year) APR 2 2	32. Registra	S Signati	J. J.	Sperte	P			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Peter Blackford Lauck 8:30 P <u>Apr</u>il 2004 24, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Annapolis 61 Southgate Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 30, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. 1917 Washington, Director 86 578-22-6849 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Exactor at most be netitied at 1 Yes 2 No Directo Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21401 61 Southgate Avenue Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Pyes 2 No If Yes, Give Year or Dates: 1942-1945 within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: þ white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) editor newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental F 27 Is marked of traumatic ever .. Pages 1 and 2 should be thent of Health and Mental Eleanor Dunlap William Jett Lauck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 61 Southgate Avenue Annapolis, MD 21401 or other train Josephine Thoms/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Apr. 28, 2004 Baltimore, MD permit. Pag Depertment Important: any injury o Baltimore Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 -23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WEAKOESS AND **Physician** YERR disease or condition resulting in death) /Medical Examiner ZHELHERS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s 1 Yes 2 No : After this certifica e funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) Certification: To 1 Tyes 2 NO 28c. Injury at Work? 27. Manns of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the mospinal within 24 hours after death.

To the Funerel Director: All 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28 Pt ce of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifie 29c. License number 29d. Date/signed (Month, Day, Year) term person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of KRIMINS 32. Rastrar's Signature 31. Date filed (Month, Day, Year) Registrar

			1 - For State Registrar		/laryland / [		rtment tificate			and M	ental F	lygie:	20	04	15028
	Physici	an	Decedent's Name (First, Middle, Las	1							2. Date of Month		Day	Year	3. Time of Death
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	or 28g	Director	10e. Street and Number				10f. Zip					10g.	Citizen of W		try?
	ath wi		13307 Sandstone I						783				U	.S.A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23e or 28e-1 show any injury or other traumatic svent, The Medical Example at must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married	12. Was Deceden Armed Forces 1 Tes 2X If Yes, Give Year or Dates	s? ] No		Vas Decede Yes, speci		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or Rican, etc.)	No-		- America k, White, e	
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ary	and M s mar	-	19a. Informant's Name/Relationship (7	ype, Print)	19b.	Mailing	g Address	(Street a	nd Numbe	r or Rura	l Route Nur	nber, Cit	y or Town, S	State, Zip	Code)
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Baltimore,	ges 1 t of Hi If iter or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State		y, crem	atory or oth	ner place		ril <sup>D</sup>	<sup>ate</sup> 26,	20c.	Location - 0	City or Tov	wn, State
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0	The law requires that the death certific Ite has been signed by the attending p bage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		at time of death		Other (spec					-	Mont	th [	Day Year
P.O.	res that the de igned by the a be detached f	/ Ph	Part II. Other significant conditions co	ntributing to death	but not resulting in	the un	derlying cau	JS8 GIVE	n in Part I.		23e. Die	d tobacco	use contrit	oute to the	cause of death?
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	To the Hospital or Attending Physician: whim's A hours after death as a first death To the Funeral Director: After this certifies completely filled in by the funeral director, p	ledicai	29a. Certifier (Check only one) Certifying Phy 2 Medicel Exemi	sician: To the best ner: On the basis of and manner si	of examination and	death /or inve	occurred at estigation, in	the time n my opi	a, date and nion, death	place, ar occurre	nd due to th d at the time	e cause( e, date a	s) and mani nd place, an	ner as sta nd due to t	ted. he cause(s)
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ئ	H-2		30. Name and address of person who co	ompleted cause of	death (Item 23a) (T		I E	vd	Sm	th	sbir		Mar	- 10.	d
	Stat	te	31. Date filed (Month, Aa) Pant)	32. Regist	rar's Signature		,		_ • • •			3 /	1 (01)	714	- 01
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			1 - For State Registrar	State of Maryla			Health and		iene	04 15029
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	Funeral Director	iei	FAHRNEY - KG 5. Social Security Number 6. Se	EDY NURSING	last birthday)		SBORO I If Under 24 Hr	s. 8. Date of Birth	WASH Year)	HNGTON  9. Birthplace (State or Foreign Country)  MARYLAND
the Maryland	28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MARYLAND WASI  10e. Street and Number		ity, Town or Lo	BOONS	SBORO		0g. Citizen of Wh	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
1215-0036 within 22 hours after death with the Maryland	nd Mental Hygiene. marked other than "natural", or Items 23s or 28s-1 show imatic event, in Medical Esaminar must be notified at	by Funeral	8507 MAPLEVILLE  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	ROAD  12. Was Decedent Ever in UAMED Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:				Specify Yes or No- nto Rican, etc.)	14. Race -	U.S.A.  American Indian, White, etc.  WHITE
N g	Hygiene. ther than "nature nt, the Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	tent's Usual Occu kind of work done OO NOT use retire HOMEM	iduring most of w ed) IAKER	orking	16b. Kind of Busin	ness/Industry  HOME
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GRACE "AILEENE" MULLENDORE

			For State A 1 1/17	State of Marylan				nd Ment		26	100	1 6	- 0 0 0
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	Physici	an	Gladys Jeanette I					N	onth oril 2	Day	Year 2004		55 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of		, I I I Z	4c. County		4	) <u>K</u>
	Examin	er	Shady Grove Hosp:			Rockvil	le			Mon	tgome	ry	
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	Director		217-46-5291	M 2 (▲F   -89	88 Yrs.	World 5	110013	No	v. 9,	1915		ylane	
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation						Od. Inside	City Limits
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9	after or Ite	F	1 Never Married 2 Married	1 □ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:	7 301(0 1 1104)	, 0.0.7	Specif		ite	
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<u>a</u>	ould be Mental warked o	To B	William A. Windso	or			Ame	lia Je	annet	te For	eacre		
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	1 and 2 Health Iem 27		John McCarvill /			Woodfie]				-	20872		
ore	Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ I	demoval from State	_	sition (Name of matory or other place	e) 5	Date 5-3-04		20c. Location			
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Bal	permit. Pages Department of Importent: If i any injury or once.		21. Signalure of Fundral Service Licent	Ellians		Name and Addres in L. Mol 401 Ridge					Home 0872		
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Вох	s that the death ned by the atter of detached for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)					onth	Day	Year
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on	nding Ph th. : After th s funeral	to I	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	. Work	<br Yes 2.⊟N			,,			
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	N N N		De Signatura and title of certifier	ap, MD			3139	1		tpril	27		2004
			30. Name and address of person the c	ompleted cause of death (Item	n 23a) (Type			• **		. 7 . 11			
	20		Suhair H. Abulfa			Grove Ro	d., #1	.00, Ro	ckvi1	le, MD	208	50	
J.	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	4 /	aks	/					
	Registi	ar	ADD 2	8 2004 Dans	A	NO DE	MAN						

	For State Registrar	State of Maryland / Dep	partment of Health and Mertificate of Death	Mental Hygiene	2006 15031
Physiciar /Medica Examine	Decedent's Name (First, Middle, Last)  JOSEPH EDW		4b. City, Town, or Location of Death	2. Date of Death Month Day APRIL 25 4c. (	79ar 2004 8.55a M
Funeral Director	Frederick Memo: 5. Social Security Number 220-20-2506 6. Sex		Frederick  // If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 13, 192	rederick  9. Birthplace (State or Foreign Country)  7. Maryland
death with the Maryland ms 23a or 28e-f ehow rrush be notified at	Usual Residence of Decedent  10a. State  10b. County  Maryland  Frederi	ck 10c. City, Town or to			10d. Inside City Limits 1X☐ Yes 2☐ No
ifter death with the Main terms 23a or 28e-for inhermulate notified	10e. Street and Number #1 Sandy Spring C		10f. Zip Code 21788	U.	zen of What Country?
J36 urs after at', or ite	3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: WWII	Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto     □ Yes 2♥ No Specify:	Rican, etc.)	4. Race - American Indian, Black, White, etc.  Specify: white
<b>35</b> € €	15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12)	cation (Giv Completed) 16a. Dec (Giv life. Weld	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)  er	king	nd of Business/Industry  Government
be fill H ad out	17. Father's Name (First, Middle, Last)		Bessie	ne (First, Middle, Maiden S Murray	,
	19a. Informant's Name/Relationship (Type Anna May — wife	#1 S	andy Spring Court,	Thurmont, N	Maryland 21788
Baltimore, permit. Pages 1 ar Department of Hea Importent: If Hem any injury or othe once.	20a. Method of Disposition  12□ Surial 2 □ Cremation 3 □ Re  14□ Donation 5 □ Other (Specify)	St. Jose	ematory or other place) ph scemetery 4/2	8/2004 Emmi	eation-City or Town, State
Physician	21. Signature of Funeral Service License  23. Part. Enter the disease, or complications, or heart failure. List only only one disease or condition	the Cline 1 cations that caused the death. Do not e	621 Opossumtown Pinter the mode of dying, such as cardiac		cal Home  ck, Maryland 21702  Approximate Interval Between Onset and Death  Zweete
executed hard in-transit	Sequentially list conditions, and any, bearing to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or of a consequence of):  Acule Rena	Heart Failure I Failure		Days
Me bur	d.	Due to (or as a consequence of):			
death certi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown		☐Ectopic pregnancy ☐ Other (specify)	2:	3d. Date of delivery Month Day Year
S, es ti	Part II. Other significant conditions con-		underlying cause given in Part I.		se contribute to the cause of death?  No 3 Probably 4 Unknown
The The page	Advanced D	ementra'		24a. Was an autopsy performed? 1 ☐ Yes 2 ₺ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
OT VITAL Physician: This certificat	axaminer?	ospital:		th (Check only one)	
thy thy all distributions of the property of t	1 Yes 2 No	28a. Date of Injury (Month, Day Year)  28b. Time Injury	of 28c. injury at	ome 5 Residence 6 28d. Describe how injury	
DIVISION C ppltal or Attending P ours after death. Israel Director: After filled in by the funeral		28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, State)	
To the Hospital within 24 hours a To the Funeral I completely filled	(Check only 2 Medical Examin	ician: To the best of my knowledge, deter: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur 29c. License number	red at the time, date and p	and manner as stated. place, and due to the cause(s) e signed (Month, Day, Year)
Twing T o	<b>&gt;</b> \( \lambda \)	2	742091		21.04
6	30. Name and address of person who co	Zaid Published Cause of death (Item 23a) (Type 23a) (Ty	801 TOLL	House An	Frederich 111)
Registra	APR 3 0 2	2004 Senera	& Sporks		

DHMH 17 Rev 1/2001

ORIGINAL

		1. Decedent's Name (First, Middle, Las		FCHD Ce	artment rtificate	t of He	ealth ar DeathK	S	Re Date of Death	g. No. 200	15032 ar 3. Time of Death 9:29 PM
Physic /Med Exam	lical	GEORGE EDWAR  4a. Facility Name (If not institution, give	Street and number)		4b. City, 1	Town, or I	Location of		Month APRIL	Day Year 21 200 4c. County of D	4 3:38 P
		FREDERICK ME	MORIAL HO	SPITAL	F	REDI	ERICK	<		FREDER	ICK
Funera Directo		5. Social Security Number 6. Se 217-40-9133	x 7. Age (In )	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, rch 14	Year) 9.1	Birthplace (State or Foreign Country) Cyland
anyland show	_	10a. State 10b. County	10c.	City, Town or Lo	cation						10d. Inside City Limits
Be-f	Director	Maryland Frederic	c Bi	uckeysto							1 ☐ Yes 2 ☒ No
with t		10e. Street and Number 6833 Buckingham 1	ano Poy 27		10f. Zip	Code 717			10	g. Citizen of What	Country?
eath	era	11. Marital Status	12. Was Decedent Ever in	1115 13			panic Origin	n? (Specifi	Yes or No-	USA	merican Indian.
13-0030 72 hours after death with the Maryland 72 hours after death with the Maryland "naturel; or Items 23a or 28e-f show	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ★ Yes 2 No If Yes, Give Year or Dates: WW		f Yes, speci 1 ☐ Yes 2	ify Cuban	Specify:	Puerto Ric	an, etc.)	Black, W Specify: W	hite, etc.
_ c * @	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual kind of wort DO NOT us	l Occupat k done du e retired)	ion uring most o	of working	1	6b. Kind of Busine	ss/Industry
IU CIC filed within t Hygiene. other than rent, the M	Som	7		Maste	r Mec	hani	С			Lime Com	ipany
be file	To Be	17. Father's Name (First, Middle, Last) William Francis	Miles				18. Mother's	s Name <i>(F</i> Flo		aiden Sumame) ances Ri	cketts
C = 17 F		19a. Informant's Name/Relationship (7) William E. Miles/S		100	ng Address L <b>in</b> ks					City or Town, State	,
Dallimore, I Demit. Pages 1 and Department of Healt, mportent: If item 2: Any Injury or other?		20a. Method of Disposition  1	Removal from State	D. Place of Dispo cemetery, crer	sition (Nam natory or oti	e of her place	)	Date / 24 / 2	2	oc. Location - City	or Town, State
partimo permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service Licens		22	. Name and	Address	of Facility	Stauf	fer Fur	neral Hom erick, MD	e, PA
		23a. Part N Enter the disease, or comp shock, or heart failure. List only o	lications that caused the d ne cause on each line.							-	Approximate Interval Between Onset and Death
death certificate be executed to the attending physician and and for use as the burial-transit		disease or condition resulting in death)  Satuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a constitution of the constituti	LMUN sequence of):	JAR.	7. 1 . 1(a	5BA How	osis O			4/>
\$ £ £	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre- 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pre			/		23d. Date of o	delivery Day Year
law requires that as been signed b	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	ndertying ca	use given	in Part I.		23e. Did toba		to the cause of death?  Probably 4 □Unknown
The The ate h	Completed						-		24a. Was an autopsy performe 1 Yes 2	prior t	
Physicien: This certificated director, p	Be	25. Was case relerred to medical examiner?	lospital:			Othon			neck only one)	<u> </u>	
ding After fune	tion: To	27. Manner of Death  1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury		c. Injury a Work?	t Nursi	28d.		ce 6 ☐Other (Sp rinjury occurred	pecify)
or Attender dear in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, larm, streecify)			2 2 3 10		Location (Stre City or Town,	et and Number or i State)	Rural Route Number,
To the Hospitel or Attention 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my liner: On the basis of examinand manner stated.	(nowledge, death ination and/or inv	occurred at estigation, i	t the time in my opir	, date and p nion, death	olace, and occurred a	due to the cau t the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
To the within To the comp	M	29b. Signature and little of certifier	P/2		29c.	License r	number	49	290	1. Date signed (Mo	nth, Day, Year)
5		30. Name and address of person who co	ompleted cause of death (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			#202	, Fre	deric	k, MD	21702	
S Regis	tate trar	31. Date filed (Month, Day, Year)  APR 2 6 2	32. Registrar's Sig		1	loon	Ka)		,		

			1 - State Ragistrar	State of Mary		irtment of H tificate of L		lental Hygie Reg	2004	15033
	Physici		Decedent's Name (First, Middle, Last)     Edna	Mae	e Mat	thews		2. Date of Death Month April 25	Day Year	3. Time of Death 7:05PM M
>	/Medio Examin		4a. Facility Name (If not institution, give s National Lutherar			4b. City, Town, or Rockvil	Location of Death		4c. County of Death Montgomer	
	Funeral Director		5. Social Security Number 6. Sex 279-42-3319 1□		yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug. 28,	ear) Cou	plece (State or Foreign ntry) a Ohio
:	be fled within 72 hours after death with the maryland tall Hygiene." and dother than "natural", or items 23a or 28a-f show event, the Madical Examination at the motified at	by Funeral Director	Usual Residence of Decedent	ry		EIC 10f. Zip Code	)854 spanic Origin? (Sp n, Mexican, Puerto		. Citizen of What Cou	ates
1215-0036	itied within 72 hours after Hygiene. Ither than "natural", or It ent, the Medical Exemin	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	1 ☐ Yes 2 ( No If Yes, Give Year or Dates:	16a. Deced	ent's Usual Occupa kind of work done of NOT use retired	Specify:	ing 16	Specify: Whi	te
and 2	0 G 0 U	To Be Co	17. Father's Name (First, Middle, Last)	Schwortz	beci	ecary	18. Mother's Nam Martl	e (First, Middle, Ma.		100
Ξ	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type Nancy Matthews (D		19b. Mailin	g Address (Street a	and Number or Rur elin Terr	al Route Number, C ace, Chev	city or Town, State, Zi, y Chase, M	D 20815
more	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Lee Crema	atory or other place atory	2004	C.	c.Location-City or T linton, Ma	ryland
Bait	permit. Pag Department Important: b sny injury o		21. Signature of Funeral Service License  23a. Part 1. Enter the disease, or compli	005H2	- W	6633 01d	Alexandr	ia Ferry		, MD 20735
	whysician and the burial-transit	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to annouate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of:		· de	10	20	Interval Between Onset and Death Many Advisory
.O. Box 6	the death certific y the attending p ched for use as	a)	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of p 1 Live birth 2 E 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
Vital Records, P.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/M	Part II. Other significent conditions con	tributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.	1 ☐ Yes 24a. Was an autopsy	prior to co	t -
Ital R	ysician: The is certificate hi director, page	a)	25. Was case referred to medical				26. Place of Deat	performe	d? death? 1 ☐ Yes	2 No
Division of V	a = B	atlon; To B	examiner?  1 Yes 2 No H  27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	at	ome 5 Residence 28d. Describe how	e 6 Other (Special injury occurred	<b>(y</b> )
Divis	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	he Hospi in 24 hour he Funer pletely fills	Medical	(Check only 2 Medical Examir one)	sicien: To the best of mer: On the basis of ex and manner stated	amination and/or inv	estigation, in my op	oinion, death occur	red at the time, date	and place, and due t	o the cause(s)
	To 1 with	Σ	29b. Signature and title of certifier	mole		29c. License			Date signed (Month,	. ,
Car	BI		30. Name and address of person who co				Leisure W		•	20906
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	berte			d,Silver S	

	1	For State Registrar	State of Maryland			t of He		Mental Hy	ygiene Reg. No.	2004	1503	
Physician /Medical Examiner		Decedent's Name (First, Middle, Las Harold  a. Facility Name (If not institution, give Millennium of Fo	Lyndon give street and number)			Mauck 4b. City, Town, or Location of Death Forestville			4c.	, 2004 County of Death		
Funeral Director	-	. Social Security Number 6. Se		nst birthday) Yrs.	If Under Months	1 Year	If Under 24 Hrs Hours Min	(Month, D	irth lay, Year)	ince Ge 9. Birth Co. 915 Vir	place (State or Fore	
bartment of Health and Mental Hygiene.  ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Mcdical Examinar must be indiffed at 8.  To Be Completed by Funeral Director	1	Oa. State   10b. County   10b.	eorge's Fo	Town or Lo restvi	11e	Code 20747				ten of What Cou	10d. Inside City Lim 1 ☐ Yes 3√√√√  ntry?	
"natural", or Itams 23 ofical Examinat must leted by Funeral	1	1. Marital Status  1. Never Married 2. Married  3. Widowed 4. Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 12 No If Yes, Give Year or Dates:	I□Yes 2	2 No :	Specify:	Specify Yes or N to Rican, etc.)		4. Race - Ameri Black, White Specify: Whi	etc. te		
ygiene. har then "natura t, the Mcdical E	-	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	cation de completed) College (1-4or 5+)		kind of wor DO NOT us	rk done dur se retired) 1esmai	n most of wo		Wo	nder Bre	•	
and Mental Hygiene. Is marked other then aumatic evant, the Me	William Branson Mauck  William Branson Mauck  Zora W						Wilson	irst, Middle, Maiden Sumame) .lson Updike  Dute Number, City or Town, State, Zip Code)				
ant of Health a	2	Sarah J. Mauck (  Oa. Method of Disposition  1 \( \nabla \) \( \nabla	20b. Pla Removal from State		Laco	ona St	treet F	orestvi: i <sup>n</sup> 1º28,	11e, l	Maryland ation - City or T	1 20747	
Land Noo153 6633 Old Alexandria Ferry Road								ome, Ind				
this certificate has been signed by the attending physician and in partial intensit and in partial intensit and in partial intensit and in partial intensit and intensit and intensit and intensit and intensit and intensit	in contract of the contract of	23a. Part1. Enter the disease, or comp shock, or heart failure. List only ommediate Cause (Final disease or condition esulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying lause. (Disease or injury hait initiated events esulting in death) Last	b. Congestive I Due to (or as a conseque Congestive I Due to (or as a conseque Coronary Ari Due to (or as a conseque Hypertension	tructi ence of): Heart ence of): tery D ence of):	ve Pu Failu	ılmona ıre			inest,		Approximate Interval Between Onset and Death	
ed by the attending physic detached for use as the ty Physician/Medical	1 2	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan- 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	iéath 3 🗌	Ectopic pre Other (spe				23	8d. Date of delive Month	ery Day Year	
been signed to should be deta	1	art II. Other significant conditions co Rena1 In	entributing to death but not result sufficienncy	ling in the un	derlying ca	ause given i	n Part I.				ne cause of death ably 4 XIUnkno	
is certificate has been s director, page 2 should To Be Completed		5. Was case referred to medical						1 ☐ Yes	psy ormed? 21 No	prior to co	psy findings availampletion of cause	
rs after death.  al Diractor: After this cer led in by the funeral direct  Certification; To B		25. Was case retered to medical examiner?  1								/)		
Diraci Diraci in by rtifik	4 Homicide determined determined 299. Place of Injury - All norme, farm, street, factory, office building, etc. (Specify)  299. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								atad			
naral i filled	2		ner: On the basis of examination	n and/or invi	estigation,	in my opinio	on, death occu	rred at the time,	date and p	ace, and due to	the cause(s)	
within 24 hours after death.  To the Funaral Director: After completely filled in by the funaral Medical Certification		(Chack only one)  2 Medical Exemi	ATTEMDING	PHYGIC		License nu				signed (Month, 2	Day, Year)	

			For State Registrar	State of	Maryland / D	epa Cer	artment <i>tificate</i>	of He	ealth a Death	and M	ental Hy	/giene Reg. No		004	15035
	Physici: /Medic		1. Decedent's Name (First, Middle Jessie Meikle					2. Date of D Month April	eath Day 25	y	2 <sup>Year</sup> 2004	3. Time of Death 1:42 A M			
<b>}</b>	Examin	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center					4b. City, T Anna	s			4c. County of Death Anne Arundel			de1	
	Funeral Director		5. Social Security Number 239-38-8471 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. last birt) 75	rs.	If Under 1 Months	Year Days	Hours	Min.	8. Date of Bi (Month, D May	av Year	28	9. Birthpl Coun Nort	ace (State or Foreign try) h Carolina
DESIGNATION CE, IMBRY JAING Z I Z I 3-UUJO Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Evant or must be multified at ance.	Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examinational be multipled at once.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Anne A 10e. Street and Number 213 Janwall St 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced (Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Frank Ward 19a. Informant's Name/Relationsl Melissa Owens/ 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Si 21. Signature of Funeral Service)	12. Was Decer Armed For 1   Yes If Yes, Give Year or Da	20 No 9 les: 16a. 140r 5+) 1 19b. 3 82 20b. Place of	13. V III 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lof. Zip of 214  Vas Decede Yes, specification of Yes 2it ent's Usual kind of work NO NOT use emake:  g Address (Holly witton (Namatory or oth Ceme in Yes 2it of Yes	403 ant of His fly Cuban No Occupate done du retired) r  Street ar Driv of of per place, tery	Specify:  ion ion ii8. Mother  Lil ad Number  4	of workin  r's Name  1ie  r or Rural  Da 29-	(First, Middle Bordug Route Numb ter, Mate 04	Unit  18b. Ki  OWN  A Maiden  Chs  Per, City o.  ID 21  20c. Lo  Anna	sed  14. Race Blace Specify ind of Bi hore Suman r Town, 037 cation -	What Count State: Se - Americack, White, e Whi usiness/Ind me State, Zip City or Tov	s an Indian, atc.  te ustry  Code)
The law requires that the death certificate be executed III	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Medical Certification: To Be Completed by Physician/Medical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 9 Unknown  onditions contributing to death but not resulting in the ur  Hospital: 1 Inpatient 2 ER/Outpatien  28a. Date of Injury 28b. Time of				Ectopic pregnancy   Other (specify)   26. Place of Death (Che: 3 DOA Other: 4 Nursing Home   28c. Injury at Work?   M 1 Yes 2 No   28f. Lice   28f. Li					23d. Date of delivery Month Day  23e. Did tobacco use contribute to the cause  1 Yes 2 No 3 Probably 24a. Was an autopsy performed? Yes 2 No 3 Probably 25e. All Were autopsy find prior to completion death? 27 Yes 2 No 3 Probably 28 Yes 2 No 3 Probably 29 Yes 2 No 3 Probably 29 Yes 2 No 3 Probably 20 Yes 2 No 3 Probably 21 Yes 2 No 3 Probably 22 No 3 Probably 23 Yes 2 No 3 Probably 24 Yes 2 No 3 Probably 25 No 3 Probably 26 Yes 2 No 3 Probably 26 Yes 2 No 3 Probably 26 Yes 2 No 3 Probably 27 Yes 2 No 3 Probably 28 Yes 2 No 3 Probably 29 Yes 2 No 3 Probably 20 Yes 2 No 3 Probably 21 Yes 2 No 3 Probably 22 Yes 2 No 3 Probably 23 Yes 2 No 3 Probably 24 Yes 2 No 3 Probably 25 Yes 2 No 3 Probably 26 Yes 2 No 3 Probably 26 Yes 2 No 3 Probably 26 Yes 2 No 3 Probably 27 Yes 2 No 3 Probably 28 Yes 2 No 3 Probably 29 Yes 2 No 3 Probably 20 Yes 2 No 3 Probably 21 Yes 2 No 3 Probably 21 Yes 2 No 3 Probably 22 Yes 2 No 3 Probably 23 Yes 2 No 3 Probably 24 Yes 2 No 3 Probably 25 Yes 2 No 3 Probably 26 Yes 2 No 3 Probably 27 Yes 2 No 3 Probably 28 Yes 2 No 3 Probably 29 Yes 2 No 3 Probably 20 Yes 2 No 3 Probably 21 Yes 2 No 3 Probably 22 Yes 2 No 3 Probably 23 Yes 2 No 3 Probably 24 Yes 2 No 3 Probably 25 Yes 2 No 3 Probably 26 Yes 2 No 3 Probably 26 Yes 2 No 3 Probably 27 Yes 2 No 3 Probably 28 Yes 2 No 3 Probably 29 Yes 2 No 3 Probably 20 Yes 2 No 3 Probably 26 Yes 2 No 3 Probably 27 Yes 2 No 3 Probably 28 Yes 2 No 3 Probably 29 Yes 2 No 3 Probably 20 Yes 2 No 3 Probably 20 Yes 2 No		
Sta Registr			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  29c. License number  29d. Date signed (Month, Day, Year)												

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Yeer **Physician** Rinaldo B. Massimino April 2004 8:24 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis
Year Munder 24 Hrs. 8. Date of Birth
(Month, Day, Yeer)
Pec. 22, 1930
Pennsylvania Anne Arundel If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Min. Hours 1 SM 2 □ F 73 188-24-0991 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28s-f show other treumatic event, the Medical Examinar must be notified at MD Anne Arundel 1 Yes 2 No Severna Park Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 McKinsey Park Drive Unit 506 21146 USA or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 %Yes 2 □ No If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🙀 No Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel County Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Public School System Music Teacher 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Enrico Massimino Margaret Troia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21146 Agnes Massimino/Wife 600 McKinsey Park Drive Unit 506 Severna Park, MI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 28, 0 = 0 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If eny injury or Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) & Sons, P.A. Ritchie Hwy. 22. Name and Addr Barranco once. Severna Park Funeral Home Severna Park, MD 21146 Gov. 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown ۾ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by funeral director, page 2 should be 1 □ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 2 No 1 Yes npatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide To the Hospital pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, 29b. Signature and title of certifie 58 who completed cause of death (Item, 23a) (Type, Print) 30. Name and address of pe 3 Kobinson 31. Date filed (Month, Day, Year)
APR 2 32. Registrar's Signature State 8 2004 Registrar

		1	For State Registrar	State of M		partment of F <i>ertificate of</i> :			ne no.2004	15037
			Decedent's Name (First, Middle, I	Last)				2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		James Lindbergh					April 2	2 200	49:29 "
	Examin	er	4a. Facility Name (If not institution, g Washington Cour		_	1 1	Location of Death		4c. County of Dea	
-	Funeral				e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Washir 9. Bir	tholage (State or Foreign
	Director		215-20-8500	1⊠M 2□F	76 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye April 26	,1927 M	aryland
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location				10d. Inside City Limits
	Maryla f sho	tor	Maryland Wash	ington		Hagerstown				1 X Yes 2 □ No
	n 18a	irec	10e. Street and Number		1	10f. Zip Code		10g.	Citizen of What C	ountry?
	23a c	ralD	260 Frederick S				740		USA	
5-0036	s i and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	If Yes Give	Ever in U.S. 1 No W.W.II	3. Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 ☒ No		cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
5-0	natur	Completed	15. Decedent's (Specify only highest	Education grade completed)	(G	cedent's Usual Occup ive kind of work done e. DO NOT use retire	durina most of workii	ng 16b	o, Kind of Business	/Industry
2121	within ene. then hs we	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	driver	1)		county g	overnment
d 2	e filed within al Hygiene. I other then vent, the we	Be Co	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, Maid		
/lar	2 should be 1 and Mental I is marked of reumatic eve	To B	Charles I. Mace	•			Mary Ye			
Maryland	d 2 sho th and t7 is mu treum		19a. Informant's Name/Relationship Frances M. Mace			ailing Address (Street  O Frederic			•	
	of Health of Health I Item 27		20a. Method of Disposition	_	20b. Place of Di	sposition (Name of crematory or other place	D		. Location - City or	
altimore,	nit. Pages artment of ortent: If II injury or o		1 X Burial 2 ☐ Cremation 3  1 4 ☐ Donation 5 ☐ Other (Spe			ven Cemete		/04 Ha	agerstown	, Maryland
Balti	permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service Li	ensee Mil	unel	22. Name and Address 415 E. Wil		IINNICH FU , Hagerst		
	to	55	23a. Part1. Enter the disease, or conshock, or heart failure. List of							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Squ Squ	mous	ell Carci.	noma oy	4 the W	ing	Onset and Death UNKNOWN
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	+ovic	Mesa	alon		~ I week
	1940	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of).	, , , , , ,	711-0			
	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
90,	ficate be executed physician and is the burial-transit	I Ex	resulting in death) Last	Due to (or as	a consequence of):					
68760,	phy:	edical		d						
Box.	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/		23d. Date of de Month	olivery Day Year
ds, P.O	ires that signed by J be deta	by	Part II. Dther significant condition	s contributing to death	out not resulting in th	e underlying cause giv	ren in Part I.			o the cause of death?
COL	w require been si should I	Completed						24a. Was an	24b. Were a	utopsy findings available completion of cause of
Re	The lar	dmo						autopsy performed	prior to death?	<b>.</b>
ital		Be C	25. Was case referred to medical				26. Place of Death		10 10	
× ×	Physici this cer al direct	2	examiner? 1 Yes 2 No	Hospital:			4   Nursing Flor	me 5 Residence		ecify)
o uc	Jing P	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inj (Month, D	ury 28b. Tim ay Year) Inju	ry Wo	yat rk? Yes 2 ∐No	28d. Describe how i	njury occurred	
Division of Vital Records,	death death ctor: y the	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of Ir	jury - At home, farm tc. (Specify)	, street, factory, office		28f. Location (Stree City or Town, S	t and Number or R tate)	lural Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direction Completely filled in by	Medical C	29a. Certifier 1 🗶 Certifying (Check only one)	Physicien: To the bes kaminer: On the basis and manner s	of examination and/o	eath occurred at the ti	me, date and place, a opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	Fo the within Fo the comple	Me	29b. Signature and title of certifier			29c. Licens			Date signed (Mon	
	- > - 0		Samir K	herri N	D	000	52064		04,23	3,2004
5	4-5		30. Name and address of person w	FMD.	1/30 OPS	L court	, HA GERS	Town 1	no 21	742
	St Regist	ate rar	31. Date filed (Month PRY2)	2004 32. Regis	rar's Signature	Sperker				

	To the within 2.	Medical	29b. Signature and title of certifier			244	1996	A	pri 20	. 1
	the f	led				29c. License	number	29	d. Date signed (Me	onn Day Vearl
	Hospit 4 hour Tunere ely fille		29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	restigation, in my op	inion, death occur	red at the time, dat	te and place, and o	due to the cause(s)
Divis	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre fy)	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
Division of Vital Records,	nding Ph ath. r: After thi e funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how		
f Vit	iysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatien	t 3 DOA Othe	627	h <i>(Check only one</i> ome 5 ☐ Resider	nce 6 Other (S	pecify)
al Re	n: The la icate has page 2							autopsy perform 1 Yes 2	prior death	to completion of cause of
cord	w requir s been si should b	Completed	yav	kmsons b	nsca			24a. Was an	24b. Were	Probably 4 Minknown autopsy findings available
s, P.O.	es that thighed by	by Ph	Part II. Other significant conditions co	,			n in Part I.			e to the cause of death?
O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c: If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
8760,	cate be execu ohysician and the burial-trar	Cal	that initiated events 'resulting in death) Last	c.  Due to (or as a consect d.	quence of):					
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	quence of):					-
•	Enysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Meta State Due to (or as a consec		ing Can	cer			Onset and Death  mmth
<b>S</b> a	805 8 8	1 11	23a. Part1. Enter the disease, or compshock, or heart failure. List only	JO. TOWLOG plications that caused the dea	JK. 13.	31 Easter	n BIVa.	North, Hag	gerstown,	MD 21742 Approximate Interval Between
ame: N Baltimore,	permit. Pa Departmer Importent any injury once.	1	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		dar Law	n Mem. Pl . Name and Addres	k. April is of Facility Doug	22,2004 glas A. I	Marylan Fiery Fur	d meral Home
ore,	ges 1 au it of Hea it item or othe		20a. Method of Disposition 1  1  □ Burial 2 □ Cremation 3 □	20b. Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other place	θ)	Date 2	Poc. Location City Hagers	or Town, State
Maryland	nd 2 she lith and 27 is m r treum	25	19a. Informant's Name/Relationship (7 Vickie Sampson/Car		1	anelot B			-	
ylan	Mental Mental arked c	ToB	Clarence M. N	Manious			Stella M	ay Carbai	ugh	
OUS 1d 21	filed wi Hygien other th	e Con	17. Father's Name (First, Middle, Last)	2	I	ndustrial		e (First, Middle, M	Shoe  Maiden Sumame)	Mfg.
21215	thin 72 e. en "nat Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of work )	ting	16b. Kind of Busine	,
Pat 5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Mardical Examinat must be notified at once.	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes 2 No If Yes, Give Year or Dates:		1□Yes 21⊠No			Specify:	
۲.	tems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - A	American Indian, Vhite, etc.
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	with the Maryland e or 28a-f show	ctor	Maryland Washingto		uithsbu					Yes 2 No
	D		214-32-4278 Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	cation		Dec. 31	, 1934 N	laryland  10d. Inside City Limits
	Funeral Director		Reeders Memoria  5. Social Security Number  6. Social Security Number		. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Examir	ner	4a. Fecility Name (If not institution, give			4b. City, Town, or Boonsb	Location of Death	ŕ	4c. County of E	ngton County
	Physici /Media		Patricia May M					Month April 19	Day Ye	
			1 - Stete Registrer  1. Decedent's Name (First, Middle, Las	t)	Cei	rtificate of l	Death	2. Date of Deat	eg. No.	3. Time of Death
					'	artment of H		, , ,	/ 11 11	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Joseph Oxendine 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 X M 2 ☐ F 216-742918 Director 39 June 1,1964 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic evant, the Medical Examiner must be notified at Director MD 1 ☐ Yes 2 XNo Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17938 Clubhouse Drive or Items 23e 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 Widowed 4 Divorced natural Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than 's my injury or other traumatic event, the Magny injury or other traumatic event, the Magny injury or other traumatic event, the Magny injury or other traumatic event, the Magnes. College (1-4or 5+) Elementary/Secondary (0-12) Correctional Officer Correctional Institution 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawson Oxendine 2 Mary Helen Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Dawn Oxendine/Wife 17938 Clubhouse Dr. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4/29/2004 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 215Seminat disease or condition Camo months resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) pe 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2) No 1 Yes or Attanding Physician: certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No 1 Unpatient Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Moni 32. A strar's Signature State Registrar

Physic /Medi Exami

Funeral Director

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

Violet Louise Osborne  4. Chy, Town, or Location of Death Washington Country Hospital  5. Social Secury Number  5. Social Secury Number  6. Saw Washington  6. Saw Washington  7. Age (in yes hat brings)  7. Age (in yes hat brings)  7. Age (in yes hat brings)  8. Social Secury Number  9. Social Se		Registrar			Certi	ticate of	Death		Reg. No	).	100
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Section   Sect	al	Violet Iouise Os	horne					And II			1 1 1 2 2 2 1
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216-88-4484   1   M 282F   79   Yrz.   Monthly   Days   Hours   Min.   Okt. 75, 1924   Maryland   Maryland   Maryland   Maryland   Washington   10c. Cby, Town or Location   10d. Cbc   Town or Location   10d. Cbc   Maryland   Maryland   Washington   10c. Cby, Town or Location   10d. Cbc   Cbc   Maryland			<u> </u>		146			lea le			
Description of Description   Description   Description of Description   Description   Description of Description   Description   Description   Description of Description   Descrip				e (In yrs. last b					irth a <i>y, Year)</i>	9. E	Birthplace (State or For Country)
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Marry Land   Washington   Hagerstown   120 code   100 citizen of Winst County?   United States   120 was December 5 ver in U.S.   13, Was December 4 Hispatric Dright?   Specify Yas or No.   14 Raze - American Indian.   120 was December 5 ver in U.S.   13, Was December 4 Hispatric Dright?   Specify Yas or No.   14 Raze - American Indian.   120 was December 5 ver in U.S.   13, Was December 4 Hispatric Dright?   Specify Yas or No.   14 Raze - American Indian.   120 was December 5 very (Durk Modelar, Paulor Ricar, etc.)   14 Raze - American Indian.   120 was December 5 very (Durk Modelar, Paulor Ricar, etc.)   14 Raze - American Indian.   120 was December 5 very (Durk Modelar, Paulor Ricar, etc.)   15 December 5 very (Durk Modelar, Paulor Ricar, etc.)   16 Wash Only (Durk Modelar, Paulor Ricar, etc.)   17 Wash Only (Durk Modelar, etc.	-										
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11. Marral Status   12. Was Decedent Ever in U.S. Armad Forest (1975)   13. Mas Decedent (1976)   13. Mas Decedent (1976	۵		<b>.</b> .						-		
Special Discourse   Spec	ra -	62 East Franklin	T						_		
15. Boroster's Education   15. Boroster's Educ	Tue-				13. Wa	as Decedent of H res, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or N lerto Rican, etc.)	0-		
15. Decedent's Education   15. Decedent's Educ	臣	1 Never Married 2 Married		No	1.5	Yes 2KINO	Specify:				
Jessier T. McDonald  Jessier T. McDonald  Jessier T. McDonald  Maude E. Smith  Thomas Osborne, Jr. / Son  20a Mantod of Disposition  1/2 Informatic Nama-Relationship (Typa, Print)  20a Mantod of Disposition  1/2 Darker Special Spe	9	3 X Widowed 4 ☐ Divorced	Year or Dates:			2.00 242.110	opoony.			Specify.	
Jessie T. McDonald  Jessie T. McDonald  Jessie T. McDonald  Maude E. Smith  Thomas Osborne, Jr. / Son  Zon Manned of Deposition  10 Jessie T. McDonald  Thomas Osborne, Jr. / Son  Zon Manned of Deposition  11 Jessie T. McDonald  Zon Manned of Deposition  12 Jessie T. McDonald  Zon Manned of Deposition  12 Jessie T. McDonald  Zon Manned of Deposition  13 Jessie T. McDonald  Zon Manned of Deposition  14 Jessie T. McDonald  Zon Manned of Deposition  15 Jessie T. McDonald  Zon Manned of Deposition  16 Jessie T. McDonald  Zon Manned of Deposition  17 Jessie T. McDonald  Zon Manned of Deposition  18 Jessie T. McDonald  Zon Manned of Deposition  19 Jessie T. McDonald  Zon Manned of Deposition  10 Jessie T. McDonald  Zon Manned of Deposition  Resthaven Crematory  2004 Frederick, McDonald  April 196, 20 Jessie T. McDonald  2005 Pleas of Peptide  2006 Pleas of Peptide  2007 Prederick, McDonald  2007 Prederick, McDonald  2008 Pleas of Peptide  2008 Pleas of Peptide  2009 Prederick, McDonald  2009 Prederick, McDonald  2008 Pleas of Peptide  2019 Pleas of Peptide  2019 Pleas of Peptide  2019 Pleas of Peptide  2019 Pleas of Peptide  2020 Pleas of Peptide  2030 Date for os as a consequence of):  2031 Date for as a consequence of):  2032 Date of os as a consequence of):  2033 Date of Deposition Pleas of Peptide  2040 Prederick, McDonald  2040 Prederick  2040 Prederick  2040 Prederick  2040 Prederick  2040 Prederick  2040 Prederick  2040 Prederic	ted			168	a. Deceder	nt's Usual Occup	ation		16b. K	ind of Busines	ss/Industry
Jessier T. McDonald  Jessier T. McDonald  Jessier T. McDonald  Maude E. Smith  Thomas Osborne, Jr. / Son  20a Mantod of Disposition  1/2 Informatic Nama-Relationship (Typa, Print)  20a Mantod of Disposition  1/2 Darker Special Spe	pie.				lite. DC	na of work done NOT use retired	during most of d)	working			
Jessier T. McDonald  Jessier T. McDonald  Jessier T. McDonald  Maude E. Smith  Thomas Osborne, Jr. / Son  20a Mantod of Disposition  1/2 Informatic Nama-Relationship (Typa, Print)  20a Mantod of Disposition  1/2 Darker Special Spe	E		College (1-4or :		Homer	naker				Own Ho	ome
Sessie T. McDonald   Maude E. Smith			t)				18. Mother's !	Name (First Middle	a Maidan		
198. Informant's Name Polationship (Type. Print)   199. Mailing Address (Street and Number or Numl Note Number, City or Town, State, Zip Code)   190. Mailing Address (Street and Number or Numl Number, City or Town, State, Zip Code)   190. Mailing Address (Street and Number or Numl Number, City or Town, State, Zip Code)   190. Mailing Address (Street and Number or Numl Number, City or Town, State, Zip Code)   190. Place of Deposition (Name of Cambridge, Cam	m									Junianie)	
Thomas Osborne, Jr. / Son  20. Method of Disposition 1	2	Jessie T. McDon	ald				Maude	E. Smith			
200. Method of Disposition   200. Place of Disposition		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing	Address (Street	and Number or	Rural Route Numb	ber, City o	or Town, State	, Zip Code)
Day Nembed of Disposition   April 26,   Place of Disposition   April 26,   Resthaven Crematory or other place)   April 26,   Frederick, Maryla   Commenter, crematory or other place)   April 26,   Frederick, Maryla   Commenter, crematory or other place)   April 26,   Frederick, Maryla   Pril 20,   Prince		Thomas Osborne.	Jr. / Son	50	) Ham	ilton A	ve. Fre	derick. N	1D 21	.701	
Resthaven Crematory   2004   Frederick, Maryla   22   Name and Agricas of Facility   23   National Properties   23   National Properties   24   National Properties   24   National Properties   25   National Properties   25   National Properties   25   National Properties   26   National Properties   27   National Properties   28   National P	-		• • • • • • •				-				or Town, State
22. Signaturo of Eupern Service Lensee  Restnaven Fruneral Services, Skkot Cody P.A.  9501 Catoctin Mtn. Hwy. Frederick, MD 21701  23. Pmin Faller the disease, or corp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximation of heart failure. Lighty one cause on each line.  Due to (or as a consequence of):  Due to (or				1			1				
236_Print foliar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximately the disease or conditions on the cause of		* 4 □ Donation 5 □ Other (Speci	<u>(V)</u>	Restha			-				
Part   Catoctin Mtn. Hwy. Frederick, MD 217/01   23		21. Signature of Funeral Service Lice	nsee		RAC	Vame and Addre	ss of Facility	Services	S 12	kot Co	dv P A
The disease, or from distance. Listgary one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Cause (Disease or injury cause)  List Underwise conditions are conditions on the cause of a consequence of):  Due to (or as a consequence of):  Due t		1/1/1/4			1950	1 Catoc	tin Mtn	. Hwv. Fi	eder	ick. M	D 21701
Sequentially list conditions as a consequence of):    Due to (or as a consequence of):		23 Pin Firer the disease, or cor	prications that caused	the death. Do						71:55	Approximate
Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate access of injury resulting in death) Last   Due to (or as a consequence of):	ш	sh de, or heart failure. Lisyon	one cause on each li	ne.			9, 000, 00				Interval Between Onset and Deat
Sequentially list conditions, if any, leading to immediate abuse. Entire Understanding to immediate abuse of the Understanding to immediate abuse. Entire Understanding to immediate and place. Entire Understanding to immediate abuse. Entire Understanding to immediate abuse. Entire Understanding to immediate and place. Entire Underst		disease or condition	50	P515	-						011001 0110 0001
Sequentially list conditions, if any, legaling to immediate growth in the ladding to immediate growth and the past 12 months?    IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   9   Unknown   1   Yes 2   No 9   Yes		resulting in death)	Due to (or as	a consequence	of):		<u> </u>				
Compared to medical axis per dispersion of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.   See 2 No 9 Unknown   Day   Day per or to completion of learn of Death   Day Pear or North of Death   D	ш		Aci	at e	Re	enal	ta.	1418			
Compared to the contribution of the contribu	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):						
IF FEMALE:   230. Was decedent pregnant in the past 12 months?   1   230. Date of delivery month   Day   Day   Date of delivery month   Day   Day   Date of delivery month   Day   Day   Date of delivery month   Day   Date of	듣	Cause (Disease or injury									
IF FEMALE:   230. Was decedent pregnant in the past 12 months?   1   230. Date of delivery month   Day   Day   Date of delivery month   Day   Day   Date of delivery month   Day   Day   Date of delivery month   Day   Date of	Xar	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of)-						ļ
In the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of 1   Yes 2   No 3   Probably 4    24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4    25. Was case referred to medical examiner? 1   Yes 2   No 3   Probably 4    26. Place of Death (Check only one)  27. Manner of Death   1   Inpatient 2   EP/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28a. Date of Injury   28b. Time of Injury   Month, Day Year)  29a. Certifier   29a. Certifier (Check only one)  29a. Certifier   29a. Certifier (Check only one)   29a. Certifier   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29a. Certifier   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Da			200 10 (0: 00	a 000040000	. 3.,.						
In the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of 1   Yes 2   No 3   Probably 4    24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4    25. Was case referred to medical examiner? 1   Yes 2   No 3   Probably 4    26. Place of Death (Check only one)  27. Manner of Death   1   Inpatient 2   EP/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28a. Date of Injury   28b. Time of Injury   Month, Day Year)  29a. Certifier   29a. Certifier (Check only one)  29a. Certifier   29a. Certifier (Check only one)   29a. Certifier   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29a. Certifier   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Da	Ca		d								-
In the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of 1   Yes 2   No 3   Probably 4    24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4    25. Was case referred to medical examiner? 1   Yes 2   No 3   Probably 4    26. Place of Death (Check only one)  27. Manner of Death   1   Inpatient 2   EP/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28a. Date of Injury   28b. Time of Injury   Month, Day Year)  29a. Certifier   29a. Certifier (Check only one)  29a. Certifier   29a. Certifier (Check only one)   29a. Certifier   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29a. Certifier   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Da	ed								- 1		
In the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of 1   Yes 2   No 3   Probably 4    24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4    25. Was case referred to medical examiner? 1   Yes 2   No 3   Probably 4    26. Place of Death (Check only one)  27. Manner of Death   1   Inpatient 2   EP/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28a. Date of Injury   28b. Time of Injury   Month, Day Year)  29a. Certifier   29a. Certifier (Check only one)  29a. Certifier   29a. Certifier (Check only one)   29a. Certifier   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29a. Certifier   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Da	2								lii.	23d. Date of d	lelivery
1   Yes   2   No   3   Probably   4	00	in the past 12 months?			h 3∐E	ctopic pregnancy			13		,
1   Yes   2   No   3   Probably   4   24a. Was an autopsy performed?   1   Yes   2   No   No   Number or Rural Route Number of Residence   28f. Location (Street and Number or Rural Route Number or R	/sic			time or acast	0 0	tilei (apeciny)					
1   Yes   2   No   3   Probably   4   24a. Was an autopsy performed?   1   Yes   2   No   No   Number or Rural Route Number of Residence   28f. Location (Street and Number or Rural Route Number or R	F -							11			
24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4    24a. Was an autopsy performed? 1   Yes 2   No 1   Normal   1   Yes 2   No 2   No 2   No 3   Probably 4    24a. Was an autopsy performed? 1   Yes 2   No 2   No 3   Probably 4    24b. Were autopsy finding prior to completion of death? 1   Yes 2   No 3   Probably 4    24b. Were autopsy finding prior to completion of death? 1   Yes 2   No 3   Probably 4    24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4    24b. Were autopsy finding prior to completion of death? 1   Yes 2   No 3   Probably 4    24b. Were autopsy finding prior to completion of death? 1   Yes 2   No 3   Probably 4    24b. Were autopsy finding prior to completion of death? 1   Yes 2   No 3   Probably 4    24b. Were autopsy finding prior to completion of death? 1   Yes 2   No 3   Probably 4    25. Was case referred to medical examiner? 26. Place of Death (Check only one) 28c. Injury at Work? 1   Yes 2   No 2   28d. Describe how injury occurred		Part II. Other significant conditions	contributing to death b	ut not resulting	in the unde	ertying cause giv	en in Part I.	23e. Did	tobacco u	ise contribute	to the cause of death
25. Was case referred to medical axaminer?  1	by l							_ 1 🗆	Yes 2	☑No 3 🗆 I	Probably 4 ⊟Unkn
25. Was case referred to medical examiner?  1	by							04- 169		24h W	autopay findings
25. Was case referred to medical examiner?  1	by							– auto	psy	prior to	completion of cause
25. Was case referred to medical examiner?  1	by										
examiner?      Yes   2   No	ρ						26. Place of I				-
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier  28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred	e Completed by			- 1 DED/0	utnationt	3CT DOA Oth				6 004 10	agaife.)
1 Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Nu	Be Completed by	examiner?	Hospital:								о <del>н</del> сту)
29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	To Be Completed by	examiner? 1 ☐ Yes 2 ☐ No	1 1 Inpatie	-			. (T)	ZOU. DESCHOO	HOW HIJUS	, occui100	
29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	To Be Completed by	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	ry 28b.		Wor	k?				
29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b.		Wor	k?				
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not detamine	28a. Date of Inju (Month, Da	ry 28b. y Year)	Injury	M 1 🗆	k?	28f. Location			Rural Route Number,
(Check only one)    Check only one   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.    Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)	To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not detamine	28a. Date of Inju (Month, Da	ry 28b. y Year)	Injury	M 1 🗆	k?	28f. Location			Rural Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Certification: To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined.	28a. Date of Injunction (Month, Date) 28e. Place of Injunction, et	y Year) 28b. y Year) ury - At home, f. c. (Specify)	Injury arm, stree	M 1 □	k? Yes 2 □ No	28f. Location ( City or To	wn, State		
	Certification: To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident 3 Suicide 6 Could not to determined  29a. Certifier (Check only)  2 Medical Examiner	28a. Date of Inju (Month, Da) 28e. Place of Inju building, et  hysician: To the best miner: On the basis o	ry Year)  28b.  ury - At home, f. c. (Specify)  of my knowledg f examination ai	arm, stree	M 1 □ t, factory, office	k? Yes 2 □ No	28f. Location ( City or To	cause(s)	and manner	as stated.
	edical Certification: To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident 3 Suicide 6 Could not to determined  29a. Certifier (Check only)  2 Medical Examiner	28a. Date of Inju (Month, Da) 28e. Place of Inju building, et  hysician: To the best miner: On the basis o	ry Year)  28b.  ury - At home, f. c. (Specify)  of my knowledg f examination ai	arm, stree	M 1 ☐ t, factory, office	k? Yes 2 □ No ne, date and pla pinion, death or	28f. Location ( City or To	cause(s)	and manner a	as stated. ue to the cause(s)
30. Name and a stress of person who completed cause of death (Item 23a) (Type, Print)  FARID MURSHED 1126 Opal Court Hager stuwn Mar	ledical Certification: To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigatic 3 Suicide 6 Could not to determined  29a. Certifier (Check only one)  1 Certifying P 2 Medical Examiner	28a. Date of Inju (Month, Da) 28e. Place of Inju building, et  hysician: To the best miner: On the basis o	ry Year)  28b.  ury - At home, f. c. (Specify)  of my knowledg f examination ai	arm, stree	M 1 ☐ t, factory, office ccurred at the tim stigation, in my o	Yes 2 □ No  ne, date and pla  pinion, death or  a number	28f. Location ( City or To	cause(s) date and	and manner at place, and du	as stated. ue to the cause(s)  onth, Day, Year)
COLUMN (Column to a september of the Column	ledical Certification: To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigatic 3 Suicide 6 Could not to determined  29a. Certifier (Check only one)  1 Certifying P 2 Medical Examiner	28a. Date of Inju (Month, Da) 28e. Place of Inju building, et  hysician: To the best miner: On the basis o	ry Year)  28b.  ury - At home, f. c. (Specify)  of my knowledg f examination ai	arm, stree	M 1 ☐ t, factory, office ccurred at the tim stigation, in my o	Yes 2 □ No  ne, date and pla  pinion, death or  a number	28f. Location ( City or To	cause(s) date and	and manner at place, and du	as stated. ue to the cause(s)  onth, Day, Year)
30. Name and a Mess of person who completed cause of death (Item 23a) (Type, Print)  FARID MURSHED 1126 Opal Court Hagerstuwn Mat	ledical Certification: To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident 3 Suicide 6 Could not to determine of the could not to determine o	28a. Date of Inju (Month, Da) 28e. Place of Inju building, et  hysician: To the best iminer: On the basis or and manner sta	ry y Year) 28b.  ury - At home, f. c. (Specify)  of my knowledg f examination arated.	arm, stree	M 1 ☐ t, factory, office ccurred at the tim stigation, in my o	Yes 2 □ No  ne, date and pla  pinion, death or  a number	28f. Location ( City or To	cause(s) date and	and manner at place, and du	as stated. ue to the cause(s)  onth, Day, Year)

		1 For State	State of Maryland / [		Health and I	Mental Hygie	ene	1501
Physic	tian	Registrar     Decedent's Name (First, Middle, Last,     Barbara Pierce			, Dodin	2. Date of Death Month	Day Yeer	3. Time of Death
/Med	ical		-test and sumbark	Ab Cib. Tourn	, or Location of Death	April	24, 2004 4c. County of Deet	
Exam	iner	4a. Fecility Name (If not institution, give Anne Arundel Medi			polis	•		_
Funera		5. Social Security Number 6. Sec		thday) If Under 1 Yea	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	Anne A	thplece (State or Foreign
Directo		Usuel Residence of Decedent	04	Yrs. Months Day	s Hours Min.	Nov. 20,		laware
Marylan I-f ehow	tor	MD 10b. County Anne Art	indel   10c. City, Tow Annapo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
3e or 28	i Direc	10e. Street and Number 956 Woodland Circ	:le	10f. Zip Code 214		100	g. Citizen of What Co USA	ountry?
DEIKIMOFE, IMBITYIBING Z.I.Z.I.3-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modral Examinar main to intifficed any injury or other traumatic event, the Modral Examinar main to intifficed any once.	by Funeral Director	11. Marital Status 1 □ Never Mamied 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2 12 No If Yes, Give Year or Dates;	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Z I Z I D-UUSO ad within 72 hours aff giene. er then "neturel", or the Wedical Exern	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	e during most of wor	king 16	6b. Kind of Business/	Industry
d 212 filed withi Hygiene. other ther	E O	Liementary/Geodinary (G-12)	3	Registere	d Nurse		Medical	
Maryland 2 nd 2 should be filed th and Mental Hygis 27 ie marked other traumatic event, II	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, Ma	iden Sumame)	
should be nd Mental marked c	2	John D. Kimmey		200		. Warren		
Mark d 2 sho th and 7 ie m traum	4	19a. Informant's Name/Relationship (Ty	1	. Mailing Address (Stre				
t and the Health Health tem 27 other tra		Chris Pierce/H		956 WOOQL3  I Disposition (Name of ry, crematory or other p	and Circle	Pate 20	is, MD 21 c. Location - City or	
Dalitimore, permit. Pages 1 a Department of Hec Important: If item any injury or othe	١.	1 ☐ Burial 2 🗶 Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	Metr	o Cremator	y 20	1 28.	Baltimore	
Dermit. Departr Import. any inji		21. Signature of Funeral Senice License	Lely	495 COV	& Sons, P	TATE COTTO	rna Darele	Funeral Home
Physician /Medica Examiner		23a Fant. Enter the disease, or complete the complete cause (Final disease or condition resulting in death)	oations that caused the de th. Do ne cause on each line.  Due to (or as e consequence	tic Cu	ying, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death
ite be executed pysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or tripu) that initiated events resulting in death) Last	Due to (or as a consequence					
tificate be ex g physician a	cai		J					1
The COLOBS, F.O. DOX 00/00,  The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnan 5 □ Other (specify)	icy		23d. Date of deli Month	very Day Year
uires that signed b	d by Pł	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause g	given in Part I.		cco use contribute to	the cause of death?
vital necord sician: The law requir certificate has been si irector, page 2 should to	Completed					24a. Was an autopsy performe 1 □ Yes 2 E	d? prior to death?	topsy findings available completion of cause of
vician: The	Be	25. Was case referred to medical examiner?	lospital:		ther	th (Check only one)		
ding Phys h. After this funeral dir	on: To	1  Yes 2  No  27. Manual of Death 1  Natural 5  Pending	28a. Date of Injury 28b. T	Time of njury 28c. Inj	ury at ork?	ome 5 Residence 28d. Describe how	e 6 Other (Specinjury occurred	eify)
or Atten after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)		_Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
e Hospital 24 hours a Funeral letely filled	edicai (	29a. Certifier 1 Certifying Physical Check only 2 Medicel Examinates	slician: To the best of my knowledge ner: On the basis of examination and and manner stated.	death occurred at the door investigation, in my	time, date and place, opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	1		nse number	29d	Date signed (Month	Dey, Year)
		the Cl	· en		7064		4/26/0	Ý
		30. Name and address of person who co	-lai- Mo	1777 Pen.	risula fara	RJ A	rndl, m	0 21012
S Regis	tate trar	31. Date filed (Month, Day, Year)  APR 2 8 2	32. Registrar's Signature	house .				

1111	7 1000	•	For State Registrar	State of	Marylan			of Health of Death			ene g. No 2 A f	1	10010
			Decedent's Name (First, Middle, La	st)						. Date of Death	Kmp 5	I I A	3. Time of Death
	Physici /Medic		Justin Charles Poss							Month APRIL	24, 20	Year 04	7:17 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, giv	street and numb	er)		4b. City, To	wn, or Location	of Death		4c. County o		
			SOLLARS WHARF R			11 E/-4 Hi . N	LUSB		r 24 Hrs.   g	S + (B)	CALV		
	Funeral Director		5. Social Security Number 6. S 216 27 5335	ex M 2□ F /	Age (In yrs. I	Yrs.		ays Hours	Min. A	Date of Birth (Month 1986)	Year) M	e. Birthpl Tylar	ace (State or Foreign
			Usual Residence of Decedent										
	show	L	10a. State 10b. County			y, Town or Lo	cation					10	Od. Inside City Limits
	8a-fs	Director	Maryland Calvert		L	usby							1 □ Yes 2 1 No
	ath with the Maryla 23a or 28a-f shov		10e. Street and Number 11739 Sidewinder Land	2			10f. Zip Co 20657				g. Citizen of Wh United St		try?
	death ms 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.V			rigin? (Speci		14. Race		an Indian.
Maryland 21215-0036	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show valcal Examilter mast be multiked at	þ	1 Mover Married 2 Married 3 Widowed 4 Divorced	Armed Forc 1 Tyes 2 If Yes, Give Year or Date	es? ZNo		fYes, specify 1□Yes 212	t of Hispanic Or Cuban, Mexica No Specify		can, etc.)	Black Specify:	White, e	itc.
5-0	"natur	Completed	15. Decedent's E (Specify only highest gra	lucation de completed)		(Give	dent's Usual C	lon <del>e</del> durina mos	st of working	1	6b. Kind of Bus	iness/Ind	ustry
21	within ene.	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	DO NDT use r	etired)	· · · · · · · · · · · · · · · · ·		,		
2	be filed withi tal Hygiene. d other than evant, Ire M		17. Father's Name (First, Middle, Last			studen	t	18 Moth	er's Name //		n/a laiden Sumame	)	
lan	d be dental	To Be	Jeffery Charles Poss						arlene 1		algo, roginario,		
ar_	s 1 and 2 should be filed within 'f Health and Mental Hygiene. itam 27 is marked other than "'other traumatic event. It's Mental	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (S	treet and Numb	er or Rural F	Route Number,	City or Town, S	tate, Zip	Code)
	ss 1 and 2 of Health a item 27 is r other tra		Jeffery C. Poss-fat	er		11739	Sidewind	er Lane I	Lusby, 1	MD 20657			
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from St.		tace of Dispo emetery, crem	sition (Name natory or othe		Dat il 28 20	_	0c. Location - C	ity or Tov	wn, State
Ē	Pag ment ant: I		`4 □ Donation 5 □ Other (Specif		Metr	cpolita	n Funera	1 Servio	<u> </u>	Ale	vendria V	/irgir	nia
Baltimore,	permit. Pages Department of I Important: If it any injury or o once.		21. Signature of Fameral Service Licer	See C				ddress of Facili	Kaus		al Home PA MD 20676		
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cau one cause on eac	sed the death h line.								Approximate Interval Between
1	Physician	2	Immediate Cause (Final disease or condition	a HUG	MEJ	DILJUR	كتحار						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):							
		_	Sequentially list conditions,	b. Due to (or	as a consequ	ience of).						-	
	uted         unsit	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury	(								- 1	
Ď,	s be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or	as a consequ	uence of):							
8760,	icate be ex physician s the buria	dical		. d									
9	ing ph	Med	IF FEMALE:										
.O. Box	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transi	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		h 2 ∏ Fetal It at time of de	death 3	Ectopic pregr Other (speci				23d. Date Mont		y Day Year
Vital Records, P.	uires that signed b d be deta	d by Pł	Part II. Other significant conditions of	ontributing to dea	th but not resu	ulting in the ur	nderlying caus	e given in Part	l.	23e. Did toba	. /	ute to the	e cause of death?
Sor	w requir been s should	Completed						-		24a. Was an	24h W	are auton	sy findings available
Re	The law ate has b page 2 s	dmc								autopsy	ed? de	or to com	pletion of cause of
ta	(D) -T	O	25. Was case referred to medical					26. Place	e of Death /	1 Yes 2		1105	2 140
₹ V	Physician: this certific ral director,	To B	examiner? XXYes 2 ☐ No	Hospital: 1 🗀 Inp	atient 2 🗆	ER/Outpatien	t 3 DOA	Other: 4 🗆 No	ursing Home	5 🗌 Resider	nce 6 X Other	(Specify,	AT SCENE
0	iding Phys th. : After this funeral dir	:uo	27. Manner of Death  1. Natural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Injury at Work?			v injury occurred		OBJ=0(5)
Sio	Attending r death. actor: After by the fune	cati	2 Cccident investigatio 3 ☐ Suicide 6 ☐ Could not b			FOUND 19		1 ☐ Yes 2 🖺	17.5				WANTEINED
Division of	or Al	Certification:	4 Homicide determined	building			eet, factory, of	tice		City or Town	eet and Number State)		Nonte Number,
	Hospital	Č E	29a. Certifier 1 Certifying Ph		St of my know		occurred at t	he time date at					
	To the Hospital or Atteni within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 X Medical Examone)		is of examinat								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	) h.			29c. Li	cense number		29	d. Date signed (	Month D	2004
			Machine	Mulhu	l			,.C.PI.E					
	1		30. Name and address of person who				-						
	<u>J</u>			KORFU	and or				imore,	Maryla	and 2120	1	
	Sta Registr	• 4	31. Date filed (Month, Day, Year) APR 2	7 2004	istra s Signal	W J	Span						

iease	Type or Print in Bia	ick indelible ink.	Ensure All Cop	Dies Are L	egipi	ę
	State of Maryland	Department of He	ealth and Mental	Hygiena	UU	Ī.

			Please  - For State Registrar AMEND ITEM #2	State of Marylar  State Of Marylar  Ma PER VERR (2831	nd / Depa	artment	of Health	and M	ental Hy	giene	2004	15	043
Р	hysici		1. Decedent's Name (First, Middle, La	st)			OI Dean		2. Date of De	Da	y Year		e of Death
	/Medic	al .	4a. Facility Name (If not institution, give		) )!		own, or Location		April	27	DDD. County of Dea	1	25 AM
	Examin	er	Washington County				stown				ashingt		
	ineral rector		5. Social Security Number 6. S 216–22–2036		. last birthday) 78 Yrs.	If Under 1 Months	Year If Und Days Hours		8. Date of Bir (Month, Da October	th sy, Year) 30,19	9. Bi	thplace (Sta ountry) MD	ite or Foreign
Aaryland	f show		Usual Residence of Decedent  10a. State  10b. County		ity, Town or Lo								e City Limits
the A	7.28e-	rect	MD Washingt  10e. Street and Number	.OII	Hancock	10f. Zip C	ode			10g. Ci	tizen of What C	ountry?	
th with	23e o	aiD	9000 Corner Road			21750	)			USA			
<b>5-0036</b> 72 hours after death with the Maryland	item 27 is marked other then "naturel", or items 23e or 28e-f show other treumetic event, I're Medical Ever Land the rediffical	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give		Was Decede If Yes, specif 1 ☐ Yes 2	nt of Hispanic ( y Cuban, Mexic		cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi	te, etc.	,
-00.	sul Ex	ed b	15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual	Occupation			16b. K	ind of Business	White	
21215-0036 ad within 72 hours affigiene,	Medis	piet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work DO NOT use	done during m retired)	ost of workir	ng			y	
212 ad with	t, the	Com	8		Truck	Drive					nty Gov	ernmen	it
be fill	even	Be	17. Father's Name (First, Middle, Last						(First, Middle		Sumame)		
Maryland 21215-003 d 2 should be filed within 72 hours th and Mental Hygiene.	mark	ဥ	James Walter Re		. 19b. Mailir	ng Address (			Mae Wel I Route Numbe		or Town, State.	Zip Code)	
t and 2 s Health an	27 is or treu		Venetta H.Reed/W	fe	9000	Corne	r Road	Hanco	ck, MD	217	50		
Baltimore, permit. Pages 1 at Department of Hea	: If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b.	Place of Dispo cemetery, crei	sition (Name natory or oth	of er place)	D	ate	20c. L	ocation - City o	Town, State	)
timent	tent: I		' 4 ☐ Donation 5 ☐ Other (Speci	y) A Ord	chard R			04/30	10.7		ock,MD		
Baltimore, permit. Pages 1 an Department of Heal	Importent any injury once.		21. Sanature of Fineral Service Live				Address of Fac				t Main MD 217		
/Me	sician edical miner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Pneur Due to (or as a conse b. Renal	nth. Do not ent	er the mode	of dying, such a					Approxir Interval	mate Between nd Death
x 68760, certificate be executed	been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conse									
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ords, P.O	n signed b uld be det	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cau	se given in Par	rt I.	23e. Did t		use contribute t □No 3 □ P	o the cause robably 4	
l Re(	ate has page 2	Completed							24a. Was autor perfo	psy ormed?	death?	utopsy findin completion o	gs available of cause of
	r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	150/0		Othor		(Check only o				
Division of lor Attending Physafter death.	After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		lnjury at Work? 1 ☐ Yes 2 [	2	ne 5 ∐ Hesi 18d. Describe I		6 □Other (Spe ry occurred	ecity)	
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Division of To the Hospitel or Attending Phys within 24 hours after death.	ne Funere Jetely fille	edical C	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	h occurred at vestigation, in	the time, date n my opinion, d	and place, a eath occurre	nd due to the	cause(s date and	and manner a d place, and du	s stated. e to the caus	e(s)
To th withir	To th	Me	29b. Signature and title of certifier			29c.	License numbe	391		29d. Da	te signed (Mon	th, Day, Year	7)
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print) 126	Opa.1	Con	rt	Н	ag 14.	l	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 1 200	32. Registrar's Sign	ature	don	11				,		

			1 - For State Registrar	State of Mar		artment of F			ene g. No. 2	Nb. 15014
ı	Physici /Medic		Decedent's Name (First, Middle, Last)     Gary Lee RESH					2. Date of Death Month	Day	Year 3. Time of Death Y
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Dea	ath	4c. County of	
			Washington County				rstown			ington
ļ,	Funeral Director		5. Social Security Number  214-54-0686  Usual Residence of Decedent	N 005	In yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mii		Ye <i>ar)</i> 1949	9. Birthplace (State or Foreign Country) Maryland
	Maryland B-f show	ctor	10a. State 10b. County  Maryland Washing		0c. City, Town or Lo	ecation agerstown	ı			10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	h with the	al Director	10e. Street and Number 115 Plantation Dr	ive		10f. Zip Code	.740	10	g. Citizen of W	hat Country?
980	172 hours after death with the Maryland "neturel", or litems 23a or 28a-f show clical Executer mat be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	I ATES 2 INO		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No		(Specify Yes or No- erto Rican, etc.)		- American Indian, s, White, etc. white
21215-0036	d within 72 ho giene. ir then "netur Ir e Modical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of w 1)	orking 1	6b. Kind of Bus	·
nd 2	be filed tal Hygi d other event,	Be	17. Father's Name (First, Middle, Last)	0	ull	ver		ame (First, Middle, M		
Z	should be ind Mental marked o	٦ ٢	George H. Resh  19a. Informant's Name/Relationship (Ty)	no Printl	40h Maili	Add (Co		uerite V.		7.0.41
Maryland	2 8 8 3		Donna Resh - wife					Rural Route Number, Hagerstow		
	item 27		20a. Method of Disposition		20b. Place of Dispo cemetery, crer					City or Town, State
<u>m</u>	uit. Pages urtment of l ortent: If its injury or o		1 X Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ding Mem.		4/24/04 I	lagerst	own, Maryland
Baltimore,	permit. P Departm Importer any injur		21. Signature of Euperal Service License	Mun		2. Name and Address E.Wils		MINNICH ., Hagerst		
	Physician		23a. Part1. Enter the disease, or compfi shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the cause on each line	death. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or at a c	sequence of):	. 8	Rice	en)		19 dan
		Jer	Sequentially list conditions,	Due to (or as a c	onsequence of):	cours	,			02
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8760,	ate be executed hysician and the burial-transit	ical	resulting in death) Last	Due to (or as a c	onsequence of):	y sel ere S	eleros	b		
.O. Box 68	at the death certificate by the attending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 [ 4 Pregnant at tim 9 Unknown	☐Fetal death 3 [	Ectopic pregnancy			23d. Date Mont	of delivery h Day Year
Ω.	uires that i signed by lid be deta	by	Part II. Other significant conditions con	tributing to death but r	ot resulting in the u	nderlying cause give	en in Part I.			oute to the cause of death?
Records,	The law requires that ate has been signed b page 2 should be deta	Completed	poon Cardi	Left Vi	en Ly'c	ular f	function	24a. Was an autopsy perform	ed? de	ere autopsy findings available for to completion of cause of aath?
Vital	sicien: certifica rector,	Be (	25. Was case referred to medical examiner?	, ,				eath (Check only one	)	
of/	this al d	<sup>2</sup>	1 Yes 2 Abo	ospital: 1 Dinpatient 28a. Date of Injury	2 ER/Outpatien			Home 5 Resider		
on		tion	1 DNatural 5 Pending 2 Accident investigation	(Month, Day Y	ear) Injury	Worl	yat k? Yes 2 □ No	28d. Describe nov	injury occurre	
Division	of or Attending after death.  Director: After in by the fune	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, str Specily)	eet, factory, office		28f. Location (Stre City or Town,	eet and Numbei State)	or Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier 1 Check only one) 1 Medicel Exemin	ician: To the best of ner: On the basis of ex and manner stated	amination and/or in-	n occurred at the tin vestigation, in my of	ne, date and place pinion, death occ	ce, and due to the car curred at the time, dat	ise(s) and man e and place, ar	ner as stated. Indicated to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed	(Month, Day, Year)
			fratfred	who M	0	Do	11898		4/22	104
H	111		30. Name and address of person who co	DRADE 3	h (Item 23a) (Type, 56 Mil	Print) ST. A	HAGERST	TOWN MI	17150	6
	Sta Registr		31. Date filed (Month APR 2 6 20	32. Rigistrar's	Signature	berke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer Month **Physician** 8:30a Thelma Rendina April 22, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Severna Park
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. 624 Kensington Avenue East Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F 87 272-07-4341 16, 1917 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Itams 23s or 28s-f shov other traumatic svent, the Mudical Exammer must be notified at 1 ☐ Yes 2 No Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 624 Kensington Avenue Easr 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after a Department of Heelth and Mental Hygiene. Throportent: If Item 27 is marked other then "natural; or item any injury or other traumatic svent, the Medical Examinations. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WW II 1 ☐ Yes 2 ☑ No Specify: Specify White à 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law Firm 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Elmore Brown Susan Crabb 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald A. Rendina/Son 624 Kensington Ave. East Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) April 26, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Glen Burnie. MD 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chenic **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months2. 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Artai 1 Yes 2 No 3 Probably 4 TUnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 20 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) ٩ filled in by the funeral 27. Mann of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO015685 30. Name and address of person who completed we of death (Item 23a) (Type, Print) 3001 5 Hanover St. Laetter KD 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar



**ORIGINAL** 

with the Marylend

death v

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

been signed by the attending physicien

this certificate has

Director: After

or Attending Physician:

28a-f show

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State of Maryland / Department of Health and Mental H	lygiene 2	U	U

15046 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Emory Clark Rice, Jr. 2004 April 11:20 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 3 M 2 □ F 73 Yrs. 8, 1930 219-28-3410 Dec. Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exemple. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b, County 1 ☐ Yes 2 No Anne Arundel Annapolis Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2545 Carrollton Road 21403 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Almed Folces: 1 GYes 2 No If Yes, Give Year or Dates: 1954–84 1 Never Married 2 Marned 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Administrator U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emory C. Rice, Sr. Estelle Svitak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ann Rice/wife 2545 Carrollton Road Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Church Cem. 4/30/2004 Upper Marlboro, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. 'Taylor Funeral Home 147 Duke of Gloucester Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 7day REMMORIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner dany leading to immediacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the attending physician and the for use as the burial-transit Physician: The law requires that the death certiticate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Nnknown recit Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an VUSCULOV certificate has autopsy performed? 2/ No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 matient ۵ 2 ER/Outpatient 3 DOA Atter this 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the within 24 hours after death To the Funaral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND 4161 32. Regiorar's Signature 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month APri 2004 Ann Wilma Rapsinski 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital 5. Social Security Number 6. Sex 7. Age (h Hagerstown If Under 1 Year If Under 24 Hrs. Washington 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. 1 M 2 F 81 Yrs 190-22-7424 03/02/23 PAUsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√2 Yes 2 □ No Fulton McConnellsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 551 N. Fifth St 17233 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Sutara LenaRapusait 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 N Third St. McConnellsbury, Pa. 17233 Carol Babinsack/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Our Lady of Hope Cem, 4/19/04 Tarentum, PA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal 13 of Funeral Service Ucensee 22. Name and Address of Facility 1037 Dual Pl. Hagerstown, Md. 21740 - 42 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Presmonia Due to (or as a consequence of) Strok 4 cs tu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Discust autopsy performed? 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ne 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of

Physician /Medical **Examiner** 

Examiner

Physiclan/Medical

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Completed

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Certification:

Medical

in by

Natural 2 Accident

3 🗌 Suicide

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4 - Homicide

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5 Pending

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**Physician** 

/Medical

**Examiner** 

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**Funeral** 

Director

28a-f show

or items 23a or

Director

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Completed

other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examinat ODGE.

Baltimore, Maryland 21215-0036

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P.O. Box 68760,

Division of Vital Records,

Physicien:

death certificate be

To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After

State Registrar

(Check only one) 29c. License number 29b. Signature and title of certifie D38764

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year) 4/16/0

Itz gerslum

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12,66,6

and 1136 ارمون

31. Date filed (Month PR 2 3 2004 egistrar's Signature

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

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			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H		nd Mental Hy	giene	2001	1501.8
	Dhunini		Decedent's Name (First, Middle, Last,	)				2. Date of De		Year	3. Time of Death
	Physici /Medic	al	Keith Brian SAWYE			T 2 =		APRIL	. 26	2004	·
	Examin	er	4a. Facility Name (If not institution, give		1	4b. City, Town, or		Death		ounty of Death	
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ı.	Director		218-82-3916	M 2□F	42 Yrs.	Months Days	Hours	Min. (Month, Da Aug. 1	1961	. Ma	ryland
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
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	or 284	Jired	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Cou	untry?
	s 23a	rail	17952 Garden Lane	40.111 D		2174				S.A.	
	ther de	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 XYes 2 1	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origii n, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	- 14	<ol> <li>Race - Amer Black, White</li> </ol>	
036	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show Jigal Exactional be notified at	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes ⊉☐ No	Specify:		s	Specify: Wh	nite
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<b>5</b>	be filed within tal Hygiene. d othar than '		17. Father's Name (First, Middle, Last)	<u> </u>	riali	Lenance	18. Mother's	s Name (First, Middle,			
ylar	Mental Mental arked c	To Be	Carroll Sawyers				Bever	rly Fleish	man		
Maryland	2 shour and M		19a. Informant's Name/Relationship (Ty		1			or Rural Route Numbe			
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Health and Mental Hygiene. artiment of Health and Mental Hygiene. artiment if itam 27 is marked othar than "natural", or Itams 23a or 28a-1 show linjury or other traumatic event, it he Medical Evaniant he notified at injury or other traumatic event, it he Medical Evaniant he notified at injury or other traumatic event, it he medical Evaniant he notified at injury or other traumatic event.		Carroll Sawyers - 20a. Method of Disposition	Father	20b. Place of Disp	Talton Ave		Baltimore,		land 21	
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alti	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Liters	9e ,				Minnich F	unera	1 Home	Maryrand
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Вох	death certific e attending p d for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			230	<li>d. Date of deliv Month</li>	very Day Year
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			1 1 Dc	book	Our. MY	) ]].	11.4	3	A a	, () J	( ) and.
	SH'AK)		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type,	Print)	041		CALI	MY 9	019004
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State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 25, Physician April 2045 2004 Blanche V. Sweeney /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-6-1919 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🛣 F 216-22-1172 84 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County rai', or itams 23a or 28a-f show Exampler roust be notified at 1 Tyes 2 No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20882 21140 Woodfield Road United States Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Photographer NIH 10 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Johnson Mary Schwartzbeck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Musser / daughter 14007 E. Annapolis Ct., Mt. Airy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot ance. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 04-30-2004 Pine Grove Mt. Airy, MD Olin L. Molesworth, P.A. Funeral Home 21. Signature of Funeral Service Licens 26401 Ridge Road, Damascus, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition COPD **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonary Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to for as a consecuance of) Examiner The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo has this certificate 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 XInpatient 2 ☐ ER/Outpatient Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \)Other (Specify) 1 Yes 2 No Certification: To 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after death uneral Diractor: in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital
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To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier BC 1082039 April 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18109 Prince Philip Drive, Suite 225, Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 8 2004 > Registrar

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5	Physici /Medio Examir	al	Decedent's Name (First, Middle     CHARLES EWELL      4a. Fecility Name (If not institution	SIMPKINS J	r)		4b. City, Town, o		Ap	ate of Death Ionth ril 26	Day Year 2004  4c. County of Dea	8:15 PM M
	Funeral Director		Southern Mary 5. Social Security Number 220-32-5029			nter last birthday) Yrs.	Clir If Under 1 Year Months Days	If Under 2	8. D. Min. Jul	ate of Birth	Prince Ge	eorge's  Thplace (State or Foreign ountry)  Shington, DC
ore, mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if items 23a or 28a-1 show any injury or other traumatic event, It a Marical Exercit er traus Exercitied and once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  205 Charmuth  11. Marital Status  1 Never Married  15. Deceden  (Specify only highes  Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle,  Charles E. Sir  19a. Informant's Name/Relations:  Eleanor L. Simp  20a. Method of Disposition  1 Burist 2 Cremation  1 Dotation 5 Other (S)	Dourt  12. Was Deceder Armed Force: 1 My vas 2 If Yes, Give Year or Dates 1's Education 1st grade completed)  College (1-40  Last)  mpkins Sr  hip (Type, Print)  Okins (Wife	Wa]  Int Ever in U.  Int Ever	16a. Decedifie. I Give life. I Paint  19b. Mailin  205 (lace of Dispo	10f. Zip Code 20602  Was Decedent of If Yes, specify Cub 1 Yes X No  Joint's Usual Occup kind of work done OO NOT use retire	dispanic Origan, Mexican, Specify:  Dation during most during most 18. Mother  Doro and Number  Ct. Wa	of working ring 's Name (First othy Mo or Rural Rout aldorf, Date	res or No- , etc.)  16b  H. Middle, Maid CIntire de Number, Ci , MD 20	Citizen of What C  USA  14. Race - Am Black, Whi Specify: Wh  . Kind of Business  Iome Impr	10d. Inside City Limits  X□Yes 2□No ountry?  erican Indian, te, etc. iite  Vindustry  rovement  as  Zip Code)  Town, State
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ň	v requires that the death certifi been signed by the attending should be detached for use as	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditio	23c. If yes, outcom 1	2 □ Fetal at time of de	déath 3□ eath 5□	Ectopic pregnancy Other (specify) derlying cause giv		_	ie. Did tobacc  1 Yes  Ie. Was an autopsy performed/	2 No 3 Pr	Day Year the cause of death?
OI VIII	Physician: this certificaral director, p	Certification: To Be Co	25. Was case referred to medical examiner?  1 Yes 2 X No  27. Manner of Death 1 Natural 5 Pendin, investig 2 Accident 3 Suicide 6 Could n 4 Homicide determined	ation ot be 28e. Place of Ir	ury ay Year)	ER/Outpatient 28b. Time of Injury me, farm, stre	28c. Injun Worl	er: 4 🗆 Nurs	ing Home 5 28d. De	☐ Ýes 2 [v] ck onlv one) ☐ Residence escribe how in	1 ☐ Yes  6 ☐ Other (Specifury occurred	
5	lo the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical Cert	29a. Certifier 1 Certifying	g Physician: To the best saminer: On the basis and manner s	t of my knov	vledge death	estigation, in my op	pinion, death	place, and due occurred at th	e to the cause the time, date a	(c) and manner as	to the cause(s)
D	Star Registr		30. Name and address of person v 31. Date filed (Month, Day, Year)  APR 3 0	0)506 M	death (Item					Α	,,,	,

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 26 2004 2:30 A M Peter S. Sagisi /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis 157 Island View Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2 F 93 1911 Director Feb. 1, Philipines 127-14-2928 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any njury or other fraumatic event, the Medical Eventual for collistic any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 157 Island View Drive 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Asian -Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: ð WWII 3 ☐ Widowed 4 ☐ Divorced Pacific Islander Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Diplomatic - U.N. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barnabe Sagisi Monica Sagisi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marina Sagisi / Wife 157 Island View Drive Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State 4 □ Donation /5 □ Other (Specify) 5/1/2004 Davidsonville, Maryland Lakemont Memorial 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature J Fin and Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a Part I. Enter the disease, or complications that caused the death. Do not enler the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (a **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Saquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) by the attending physicien and tached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Weknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 X No rector, page 2 2 🗆 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 517 esidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident М investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month/Day, Year) 29b. Signature and title of certifier npleted cause of death (Item 23a) (Type, Print 30. Name and address of person who co Rin 31. Date filed (Month, Da 32. Régistrar's Signature State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Steven J. Schuster State of Maryland / Department of Health and Mental Hygiene 04-2751 1 State upend item#23a,27,2&a-f,PFR MF,G831 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 6:11 P M 21, Steven Joseph Schuster April 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5764 Pindell Road Lothian Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1<del>√</del> M 2□ F 214-02-4661 Yrs. Feb. 6, Director 1976 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be rediffed at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 N No Anne Arundel Co. Lothian Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20711 U.S.A. 5764 Pindell Road Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Company Carpenter 9 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Karen Frances Schuster William Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5764 Pindell Road, Lothian, Maryland 20711 Karen F. Schuster (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 26. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Clinton, Maryland \*4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Sentes itenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Wether W. I.e. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Immediate Cause (F disease or condition resulting in death) **Physician** Narcotic Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last b Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the a detached 9☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nnknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 certificate 1 XYes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 XYes 2 □ No 4 Nursing Home 5 Residence 6 X ther (Specify) At scene this 28a. Date of Injury 28b. Time of Cartifury 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 🗀 Natural 5 Pending death. 1 Yes 2 No unknown investigation after death Director: / 2 Accident 6:02p 4/21/04 the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗀 Homicide 0 residence 5764 Pindell Rd, Baltimore, MD within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. April 22, 2004 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD ANA 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dav. Year) 32. Registrans Signature State

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Registrar

2004

			For State Registrar	State of Ma	aryland /	•	rtment of F			, ,	jiene leg. No.	200	4 15055
	Physicia	an	1. Decedent's Name (First, Middle, Las	t)					2.	Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic	al	NORMAN  4a. Facility Name (If not institution, give	CARLI	SLE	THO	MPSON 4b. City, Town, o	r I continu		April		, 200 County of Dea	
	Examin	er	Frederick Memo		pital		Frede		Di Dealli			reder	
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last l	birthday)	If Under 1 Year Months Days	If Under	24 Hrs. 8. Min.	Date of Birth (Month, Day	1		thplace (State or Foreign
	Director		21, 03 00.0	<b>Ж</b> М 2□ F	91	Yrs.	Moralio Bayo		Se	ept 7	1912	P1e	asantvilleMD
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	e-f sh	ctor	MD Frede	rick	Kno	xvi1	.1e						1 ☐ Yes 2 █No
	3a or 28	ai Dire	10e. Street and Number 4121 Weston Drive				10f. Zip Code 21	758			10g. Citiz	zen of What C USA	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: if item 27 is marked other than "neturel; or items 23a or 28e-f show any injury or other traumetic event, I'm Medical Erai: it at most be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent If Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:		i	Vas Decedent of H i Yes, specify Cuba ☐ Yes 2 No	lispanic Origin, Mexican		y Yes or No- an, etc.)		14. Race - Am Black, Whi Specify:	
Maryland 21215-0036	I within 72 ho liene. r than "netur I've Medicul.	ompleted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2			(Give life. L	lent's Usual Occup kind of work done DO NOT use retired	during most	t of working		B&0	Railr nswick	oad
and ?	be filed ntal Hyg ad othe svsnt,	Be	17. Father's Name (First, Middle, Last) John F. Thompson							First, Middle,	_	-	
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Baltimore,	Pages 1 a nent of He ant: if item ary or othe		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify				sition (Name of natory or other place s Cemete		Date 4/26/2			cation - City or	
Balt	permit. Departr Imports any inj		21. Sign by cot Further in rice Licen Barbara A. Will	liams, Own	ier	- 22 1	Name and Addre ohn T. W 00 Peter	ss of Facilit illia svill	ms Fui e Road	neral 1, Bru	Home nswi	ck, MD	21716
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. D	o not ente	er the mode of dyin	g, such as	cardiac or re	espiratory arr	est,		Approximate Interval Between Onset and Death
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Box	death cer e attendir id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal dea		Ectopic pregnancy Other (specify)				2	3d. Date of de Month	livery Day Year
P.O.	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions of	ontributing to death bu	ıt not resulting	g in the ur	derlying cause giv	en in Part I.	. 1015-011	23e. Did to	bacco us	se contribute t	the cause of death?
rds	w requires been sig should b	ed b	Chromi obs	misi	i pu	lmo	meny di	Sla	re	† □ Y	es 25	<b>K</b> No 3□P	robably 4 Unknown
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			State of Maryland / Depa  1 - For State Registrar  Cer	rtment of Health and Men	ntal Hygien		5056
	Division		Decedent's Name (First, Middle, Last)		Date of Death		Time of Death
	Physicia /Medic		Ella M. Tyrrell		Month 1 22	, 200 <del>°4</del>	1538 м
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	C. County of Death	
			22780 Laurel Glen Rd. Unit 107			St. Mary's	
ŀ	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	Date of Birth Month, Day, Year	9. Birthplace (Country)	(State or Foreign
	Director		110-09-7807 A 86	Au	g.30,19	17   Scot1	and
	land ow		10a. State 10b. County 10c. City, Town or Loc	ation		10d. In	nside City Limits
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	deal	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married	Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - American In- Black, White, etc.	dian,
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5-0036	be filed within 72 hours after death with the Maryland tal Hygiene d other then "natural", or items 23a or 28e-f ehow event, the Medical Examiner mout be notified at	d by	3 Wildowed 4 Divorced Year or Dates:				
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Baltimore,	permit. Pages Department of Importent: If i any injury or o		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility	1451	Dares Bea	ch Rd.
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	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
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Sec.	e law has b je 2 sl	nple	Advanced Age		24a. Was an autopsy	24b. Were autopsy fir prior to completi death?	ndings available ion of cause of
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Viita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Ch			
	Phys this ral di	. To	1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 2. Manner of Death 28a. Date of Injury 28b. Time of		5 esidence Describe how inju		
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/IS	or Attend after death Director: #	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office 28f. I	Location (Street a	nd Number or Rural Rou	te Number,
á	al or after	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Stat	e)	
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	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invariation and manner stated.		t the time, date an	d place, and due to the c	:ause(s)
	With Con	Σ	29b. Signature and title of certifier	29c. License number	1	ate signed (Month, Day, )	*
•			Mitten MO	D0058572	April	1 24, 2004	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Do058572 Suite 310 Prince F.		4400	
	<u>9</u> Sta	to.	31. Date filed (Month, Day, Year) 32. Registray Signature	, suite 310 France F.	ulden CK	MU 2067	<b>/</b>
	Registr		31. Oxfe filed (Month, Day, Year)  APR 2 6 2004	Sparle			

State of Maryland / Department of Health and Mental Hygiene 2 1 1 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Dav Year Brenda Lee Turner April /Medical 2004 3:25 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 461 Avon Court Friendship Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month. Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1□M 2∏F Director 579-84-8184 Yrs 46 Oct 21, 1957 Washington, D.C. Usual Residence of Decedent death with the Maryland 10a, State 10b. County "natural", or items 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Anne Arundel Direct Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 461 Avon Court 20758 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Mudical Externi 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Specify white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) registered nurse health care 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Roy Temple Lawson Sadie Virginia Grierson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Turner, Jr., spouse 461 Avon Court, Friendship, MD 20758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State So. Memorial Gardens 4-27-2004 ` 4 ☐ Donation 5 ☐ Other (Specify) Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ellean Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cervical cancer two years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for sels-supremestration the attending physician and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No 1 Tes this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 Pending To the Hospital or Attendii within 24 hours after death, To the Funeral Director: Al investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0051301 April 26, 2004 30. Name and address of person wo completed cause of death (Item 23a) (Type, Print) 10 Kevin Knopf, 900 Bestgate Rd., Ste 300, Annapolis, MD

Registrar DHMH 17 Rev 1/2001

State

32. Registr Signature

M.D.

7 2004

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 15058 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 24 2004 4:10 James April Vaughn a Edward /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Dunkirk 10700 Ward Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F 1934 Wash., Director 218-30-8261 D.C. Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f show r is marked other than "neturel" or Itams 23e or 28e-f shot treumatic event, the Medical Exertiner must be redilined at 1 Yes 2 No Directo Dunkirk Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20754 USA 10700 Ward Road death 1 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) automobile mechanic automobile repair permit. Pages 1 and 2 should be filled. Department of Health and Manta Hygin Importent: If item 27 is marked eny injury or other the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vaughn Lillie 2 Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10700 Ward Road, Dunkirk, MD 20754 Mabel L. Vaughn, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 4-27 2004 Brentwood, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William Owings, MD Rausch Funeral Home, P.A., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final syriamons cell cancer **Physician** Havanced disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a currectioned of Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 ☐ Yes 2 No 2 No director. Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To his funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death death Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 0 D59061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 111 Prince Frederick 110 Hosp

DHMH 17 Rev 1/2001

State

Registrar

32. Registra s Signature

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Year)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 15059 For State Registra AMEND TIEM #24a PER PHY C831 5/11/04 Aftificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April Physician Ruth Elizabeth Wetzel 5:45P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ctr. Examiner Westminster Nursing & Rehabilitative Westminster Carroll If Under 1 Year | If Under 24 Hrs. B. Date of Birth (Month, Day, Year Jul. 6, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 ☐ F Months Hours 92 215-10-5420 Yrs. Maryland Director Usuel Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County in than "natural", or itema 23a or 28a-f show the Medical Evaninar must be notified at 1 Yes 2 No Maryland Carroll Union Bridge Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 295 Clear Ridge Rd. 21791 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White <u>ک</u> 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) seamstress clothing factory is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be it of Health and Mental John Elias Welty ပ Oda Belle Lock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray E. Wetzel/ son 295 Clear Ridge Rd. Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Rocky Hill Cemetery 4/5/2004 ¹ 4 □ Donation 5 □ Other (Specify) nr. Woodsboro, MD 21. Sign ture of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home New Windsor, MD 21776 Verine 310 Church St. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 3 ☐ Probably 4 ☑ Unknown 2 🗆 No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Vital XX No 1 ☐ Yes Attending Physician: 25. Was case referred to medical After this certification 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပို 1 Inpatient 2 ER/Outpatient 3□ DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 🗌 Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ò 29a. Certifier t 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. F P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) To 1 EW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Busills 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) State Amend#10e, perFH, 4/30/04, FCH Gertificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** 29, April 3:23A. Betty L. Walker /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Homewood at Crumland Farm | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 20, 1923 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F 81 Iowa Director 485-18-1039 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28e-1 show the Medical Examiner must be notified at 1 Yes 21 No Frederick Frederick Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7407 Willow Road U.S.A. 21702 7407 Williw Road 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 ☐XNo Specify. white Maryland 21215-0036 þ 3K Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) d Hygiene. Clerk Heavy equipment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be f h and Mental H 7 is marked of Winnie Hays James Burton Davison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 : Department of Health ar Importent: If Item 27 Is any injury or other trau. 21704 8208 Virginia Lane, Frederick, Maryland Shirley Jack - Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3XXX Removal from State 5/4/2004 American Mausoleum Peoria, Illinois 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Karon Capulle Glene Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Dheumonia /Medical Due to (or as a consequence of): **Examiner** ) em en Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. physiclans Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 25 No 1 ☐ Yes 7 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital: 2 No Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? CARMON to Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Płace of Injury - At home, larm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title q certifier MDD16428 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 300 West Ninth Street, Frederick, Maryland Casper E. Cline, II 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10	d. Inside City Limits
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Maryland 2	es 1 and 2 should be f of Health and Mental I f itam 27 is markad ot r othar traumatic eva	Ĕ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	and Numbe	r or Rural I	Route Number,	City or Town, Sta	ite, Zip C	Code)
	and 2 ealth a n 27 is		Pat Hevner/ Daug	nter		11419	Handboa	rd Rd	., Un	ion Bri	dge, MD	217	19
ore	or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	. □Removal from	State 20b. P	lace of Dispo emetery, cren	sition (Name of natory or other place	θ)	Dai	te 2	0c. Location - Cit	y or Tow	n, State
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fuberal Service Lie	ensee	4	16	Name and Addres	s of Facility umtow	y Sta n Pik	uffer F e Frede	uneral H rick, M	lome 21	702
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وَ	rtificate ng phys as the		45 FEMALE.	·									
Rox	eath certific attending p	an/h	fF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1☐Live b	tcome of pregna pirth 2 Petal	fdeath 3	Ectopic pregnancy				23d. Date o Month		y Day Year
o.	The law requires that the death certific thas been signed by the attending p tage 2 should be detached for use as	Physician/Me	1 Yes 2 No	4∏Pregr 9☐Unkn	nant at time of de own	eath 5□	Other (specify)				i iii iii ii		
٦.	that the		Part II. Other significant condition	s contributing to d	eath but not resu	ulting in the ur	nderlying cause give	en in Part I.		23e. Did toba	icco use contribu	te to the	cause of death?
ecords,	quires en sign	d by	Chronic Leti	- Pleu	ral ET	fusion				1 🗆 Yes	2 □ No 3[	] Probal	oly 4 Onknown
O O	aw requ s been 2 should	Completed								24a. Was an	24b. Wer	e autops	sy findings available
2	sician: The law certificate has b irector, page 2 s	шо								autopsy perform	ed? dea	r to com: th? Yes 2	oletion of cause of  ☐ No
Vital H	stan: artifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place	of Death (	Check only one			
0	Attending Physician: r dea.h. ector After this certific by the funeral director,	မ	1 Yes 2 No			ER/Outpatien	-	4 LI NUI	-		ce 6 Other (	Specify)	
Ä	ding P h. After funera	lon:	27. Manner of Death  Natural 5 Pending		of Injury th, Day Year)	28b. Time of Injury	Work	rat ⟨? Yes 2.⊟N		d. Describe hov	injury occurred		
Division	Attender death ector	licat	2 Accident investiga 3 Suicide 6 Could no determin	t be	of Injury - At ho	ome, farm, str	eet, factory, office	103 2		f. Location (Stre	et and Number of	or Rural	Route Number,
5	ō # io ⊆	Certification:	4  Homicide	build	ing, etc. (Specify	v)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town,	State)		
	To the Hospital or within 24 hours afte To tha Funeral Discompletely filled in	edical (		caminer: On the b			occurred at the time restigation, in my op						
	To the within To the Compl	Me	29b. Signature and title of certifier	1	100 0		29c. License			29	d. Date signed (A	fonth, D	ay, Year)
:	. 7		30. Name and address of person w	) Con	se of death /Itom	23a) (Tune		035	152		4/2:	5/0	7
	1		J.L. Kranzz	MO	/ 80 Registrar's Signa	Thos	Johnson	0-	Fr.	ederici	1 me	)	21702
	Sta Registi		31. Date filed (Month, Day, Year) APR 2		Sensor		9 Soo	ella)	′				

State of Maryland / Department of Health and Mental Hygiene 00 1 15062 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Wheeler, Sr April 25, 2004 Sherman 6:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing Home and Rehab Ctr. Clinton Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
April 27,1910 Virginia 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1√2 M 2□F Months Days Hours Min. 93 064-03-5455 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits 7 is marked other then "neturel", or Items 23a or 28e-f show treumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Prince George's Clinton Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 20735 U.S.A. 5908 Sellner Lane death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Ite eny injury or other treumetic event, the Medical Eventures. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: Specify: Black þ 3 Navidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Maintenance Hotel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wheeler Samue1 Lucy Messick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Wheeler (Son) 5908 Sellner Lane Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maple Grove Cemetery 20a. Method of Disposition 20c. Location - City or Town, State May Date, 1 Burial 2 Cremation 3 Removal from State New York City 2004 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Jervice Ligensee 22. Name and Address of Facility Lee Funeral Home, Inc. Down .. 6633 Old Alexandria Ferry Road Clinton, MD20735 M00257 Man 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Failure /Medical Due to (or as a consequence of). **Examiner** Malignany Hypertension Years Securitielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit Parkinson's Disease Years Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medlcal as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X X Inknown Organic Brain Syndrome Completed History of Septicemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a.. autopsy performed? Yes 24 No 2 No 1 ☐ Yes 1 Yes or Attending Physiclen: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide the Hospitel To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-51520 4-23-24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahran Pishdad MD 1328 Southern Avenue SE Washington DC #310 20032 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State APR 3 0 2004 Registrar

			For AMEND# 24a,26	State of Maryland	i / Depa		lealth ar		Hygier		1500
			- State Ragistrar 4/28/04 Per Phy.	. CMH	Cer	tificate of	Death	1.5		No. 2004	
Н	Physicia	an	Decedent's Name (First, Middle, Last)					Mon		Day Yeer	3. Time of Death
	/Medic	al	Elizabeth  4a. Facility Name (If not institution, give str			4b. City, Town, o	r Location of I	<u> </u>		2004 4c. County of Death	12:20 b
	Examin	٠. ا								Anne Ar	
	Funeral		1175 Madison Str 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	Annano If Under 1 Year Months Days	If Under 24	Hrs. 8. Date Min. (Mor	of Birth	ar) 9. Birth	pplace (State or Foreign untry)
(a)	Director		210 00 0710 -	M 201F 84	Yrs.	Worth's Days	110013			1919 Ma	ryland
	and w		Usuel Residence of Decedent  10a. State 10b. County	10c. City,	. Town or Lo	cation					10d. Inside City Limits
	Manyli f sho	ō	Maryland Anne Ar	undol Ann	apoli	C					1 kgYes 2 □ No
	r 28a	Directo	10e. Street and Number	didel Am	a por	10f. Zip Code			10g.	Citizen of What Co	untry?
	death with the Maryland rms 23a or 28a-f show r. roust be nutitied at		1175 Madison Str			2140	03			USA	
	r dea	Funerai	11. Maritar States	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	3. \ 13. \	Was Decedent of F f Yes, specify Cub	lispanic Origir an, Mexican, F	n? (Specify Yes Puerto Rican, e	or No- itc.)	14. Race - Amer Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 1 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2√ No	Specify:			Specify: B	lack
Maryland 21215-0036	filed within 72 hours after Hygiene. other then "naturel", or Ite ent, the Medical Exactina		15. Decedent's Educa	ation	16a. Deced	ient's Usual Occup	pation	of working	16b	. Kind of Business/l	Industry
215	e. en "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	n working	C	leaning	
2	ygien ygien t, the		8th	0		Domest		s Name (First,			
and	ould be fil Mental H karked ott tatic even	Be	17. Father's Name (First, Middle, Last)								
7	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than 'naturel', or liems 23a or 28a-f show aumatic event, the Maryleat Exercities must be nutilised at	ပ	Eugene Baden  19a. Informant's Name/Relationship (Typ)	oe, Print)	19b. Mailir	ng Address (Street		ira Bet o <i>r Rural Rout</i> e		ty or Town, State, 2	(ip Code)
<u>≅</u>	and 2 sealth and 2 sealth and 27 is		Patricia Foote (		53	Juliana	Circ	lo Fac	st An	nanolis	Md. 2140
re,	Item		20a. Method of Disposition	20b. Pla	metery, crer	natory or other pla	ce)	Date	20c.	napolis Location - City or	own, State
Ē	Pages ment of I ant: If Ite ury or o		DDenation 5 ☐ Other (Specify)	BES	sgate	e Memor:	ial   4	1/14/04	4 A	nnapoli:	s, Md.
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic 9069.		21. Signature of Funeral Service Licenses	0	22	Name and Addre		ns Moi	rtuar	v. P.A.	
	0.0 ⊆ <b>4</b> 0		23a. Part1. Enter the disease, or complic	ear MOOY85	Do not ent	21 West	St. A	nna po	lis,	y, P.A. Md. 214	0 1 Approximate
П			shock, or heart failure. List only one	e cause on each line.	000	A L A	10.1	Davis	Can		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to for as a consequ	ence of):	mydean	dali	ntene	HOY_		
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687	death certificate t attending physic of for use as the b		d.			-					
Box	n certi	In/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnar		∃Ectopic pregnanc	·v			23d. Date of deli	,
	that the death cer ed by the attendir detached for use	sicia	in the past 12 months?	4□Pregnant at time of de		Other (specify)				Month	Day Year
P.0.	d by the	Phy	9 Unknown  Part II. Other significant conditions cont	tributing to death but not resu	ilting in the u	nderlying cause gr	ven in Part I.	230	e. Did tobacc	co use contribute to	the cause of death?
	The law requires that the ate has been signed by thoage 2 should be detache	Completed by Physician/Medi	CONCINTIVE LOW	V+ feiture	Hì	NINX	-	CA	1 🗆 Yes	\ .'	obably 4 Unknown
Sor	v requ	ietec	Mus enclusioned as 5	1	,	7		24	a. Was an	24b. Were au	itopsy findings available
Re	he law e has age 2 :	dmo	rape con ester	Λ.				_  ,_	autopsy performed Yes 2 X	? death?	completion of cause of
tal		a	25. Was case referred to medical				26. Place o	of Death (Chec		10 103	22.00
of Vital Records,	Physician: this certific ral director,	To B	examiner? 1 Tes 2 No		ER/Outpatie	11			-	e 6 □Other (Spec	cify)
	ing Pl		27. Manner of Death  1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ork?		scribe how it	njury occurred	
Division	or Attending after death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, st		Yes 2 N		ation (Street	t and Number or Ru	ural Route Number,
Di<	atter Direct	Certification:	4 Homicide determined	building, etc. (Specify	')	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City	or Town, S	tate)	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinat	wledge, deat	h occurred at the t	ime, date and	place, and due	to the cause	e(s) and manner as	stated.
	To the He within 24 To the Fu	ledical	one)	and manner stated.						Date signed (Monti	
	To To con	Σ	29b. Signature and title of certifier	1 ( N			se number	29	250,	LI/19/	) 4
			Pet le	imple d cause of death (Item	23a) /Tuna		1602			7/1-/0	1
			30. Name and address of person who co	Peukway - Sa	ajak	ste 676	); Au	ine poli	SIN	10 51	101
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	1.00		1			
	Regist	rar	APR 28	ZUU4	100						

Craig Walden 04-02763 RPD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Menta	I Hygiene	16
State of Maryland / Department of Health and Menta  Certificate of Death	Reg. No.	10

	RPD	4	For State Regist <i>r</i> ar	State of M	aryland		artment of F tificate of i			gienez Reg. No.	004	15065
			Decedent's Name (First, Middentification)	dle, Last)					2. Date of De	ath	Vone	3. Time of Death
	Physicia		Craig Michael	l Walden					April	Day 22 - 2	Year 004	0847 A M
	/Medic Examin		4a. Facility Name (If not institution	on, give street and number)	)		4b. City, Town, a	r Location of Deati			ounty of Death	
			Prince George'	s Hospital C	enter		Cheverly			Pr	ince Ge	orge's
	Funeral		5. Social Security Number	6. Sex 7. Aç	ge (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	h y, Year)	Coul	
	Director		216-13-0425	¹¼M 2□F 32	<u> </u>	Yrs.			Aug. 4	197	1 Mary	land
	and		Usual Residence of Decedent  10a. State 10b. Count	ty	10c. City,	Town or Lo	cation		<u> </u>		1	lod. Inside City Limits
	Manyl f eho	ō	VD 0-1	1	Cha	annon'	lro Doogh					1X Yes 2 □ No
	the 28a	Director	MD Calve  10e. Street and Number	ert Co.	cne	sapea	ke Beach			10g. Citize	n of What Coul	ntry?
	3a or		8072 Silver F	ox Way			20732			U.	S.A.	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	- 14	Race - Americ Black, White,	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It marked other then "netural", or Items 23a or 28a-f show other traumatic event, the Medical Evertimet must be notified at	by	1 ☐ Never Married 2 💢 Ma 3 ☐ Widowed 4 ☐ Divorce	arried 1 ☐ Yes 2 🔯	[No	}	1 □ Yes 2 X No	Specify:	o riicari, etc.,			ite
2-0	72 ho	eted	15. Decede	ent's Education nest grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind	of Business/In	dustry
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	e filed within al Hygiene. other then ' vent, the Me		17. Father's Name (First, Middle	+4		Marke	ting Rep		LVE ne (First, Middle,		try Com	pany
anc	be findal Fed of	Be	Ronald H. Wal					_	ou Metscl			
ž	2 should be and Mental is marked isumatic ev	7	19a. Informant's Name/Relation			19b. Mailir	ng Address (Street				Town, State, Zit	Code)
Maryland	d2s than trau				thon)		Drawfie			15		
	s 1 and 2 of Health item 27 i		Ronald Barry 20a. Method of Disposition	raiden (bio	20b. Pla	ace of Dispo	esition (Name of matory or other place		Date	20c. Loca	ition - City or To	own, State
altimore,	eg = 5		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State (Specify)	a 1		Mem. Gard	dens April	il 27,	David	sonvill	e, Marylan
Ħ	permit. Pa Departmer Important any injury		21. Signature of Fundar Service		2		2. Name and Addre	ss of Facility	Funera	I Hom	e Calve	rt, P.A.
Ö	Depar Impor any ir		Michael W	Lee		8	125 South	hern Mary	land Bl	vd.,	Owings,	MD 20736
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that cause ist only one cause on each	ed the death. line.	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Head	and	ahdon	nind in	nines				Onset and Death
	/Medical		resulting in death)	Due to (or as			(					
	Examiner	_	Sequentially list conditions,	b								
	ed is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a a cousada	ende sty.						
	xecut and al-trar	Examln	that initiated events resulting in death) Last	c. Due to (or as	s a consequ	ence of):						
68760,	ficate be executed physicien and is the burial-transit	al E		4								
687		edlcal		0.								
Box	death certifi e attending ed for use as	ian/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth			∃Ectopic pregnanc	v		23	d. Date of deliv	•
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specify)	7			Month	Day Year
P.0	The law requires that the de the has been signed by the a bage 2 should be detached f	Physici	9 Unknown					i. B. at	ana Dida		a anatolikuta ta t	he cause of death?
	res th igned be de	b	Part II. Other significant cond	itions contributing to death	but not resu	iting in the u	inderlying cause giv	/en in Paπ i.	1 🗆			pably 4 Unknown
ord	w requir been si should	Completed										
ec	alaw hasb e 2 sl	nple							24a. Was			opsy findings available impletion of cause of
of Vital Records,									1 Yes	2□ No		2□ No
Vit	60 B	o Be	25. Was case referred to medi examiner?	Hospital:	2 M	ER/Outpotion	nt 3 DOA Ott	200	ath (Check only only only only only only only only		Other (Speci	6.0
of	Phys r this ral di	1	1X Yes 2 No 27. Manner of Death	1 ☐ Inpat	iury	28b. Time of			28d. Describe			(9)
on	ding Pt th. : After th s funeral	tlor	1 □ Natural 5 □ Pen- 2 ☑ Accident inve	ding (Month, Distigation   122 2		Injury		rk? ]Yes 2.∭ZNo	diver	in a	ollision	wire tree
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 □Cou	lid not be 28 Place of Ir		me, farm, st	reet, factory, office	11 (1111)	28f. Location ( City or To	Street and	Number or Rur	al Route Number,
ă	i. 5 te o	Cert	4   Horricide	ballaing, e		oadw	dy				enand	MD
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical (	(Check only 2 Medic	ying Physician: To the bes	of examinati							
	the hin 24 the f	Med	one) 29b. Signature and title of certi	and manner s	stated.		29c. Licens				signed (Month,	
	To Too			211	2 1	1 h	O.C.				23, 20	
				Breezher						·	. 20, 20	•
	ID		30. Name and address of person	Weenberz M	. D	23a) (1ype,	la Penn S	treet, B	altimore	, Mar	yland 2	21201
		ate	31. Date filed (Month, Day Ye	ar) 9 C SZ. Regis	strans Signat	ure						
	Regist		AP	R 2 6 2004	Bloom	s St.	Spelle	9				
DI	HMH 17 Rev 1/2	2001		-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Da Α 2 Partoara Lawrence Wilson 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Calvert Solarans Solomons Nursing Center
5. Social Security Number 6. Sex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Sept. 13 1917 9. Birthplace (State or Foreign Country) Massachusetts 7. Age (In yrs. last birthday) Months 1 ☐ M 2 ☐ F 013 07 0601 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Maryland Calvert Lusby 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20657 United States 13370 Joy Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Business consultant 12 Revion Conporation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Grace Ella Putram Marino Antonio Nobili Lawrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Normen Wilson-husband 13370 Joy Road Lusby Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Funeral Service 26 2004 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Alexandria Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rausch Funeral Home PA 4405 Broomes Is. nD. Port Republic MD 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): F. bullation Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1□ Yes 2\No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

26, 2004

**Examiner** the burial-transit The law requires that the death certificate be executed physician and Box 68760, use as 0 Records, Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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itеms 23a

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Martless any injury.

**Physician** /Medical

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Completed by Funeral

Be

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with the Maryland

death

a F FEMALE: 27. Manner of Death ₽ Natural 2 Accident 3 Suicide 4 - Homicide

Examiner

Medic	-
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To Be C	-
tification: 1	1
ai Cer	-

29a. Certifier 29b. Signature and title of certified

0		
Re	State	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

5 Pending

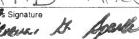
investigation

6 Could not be determined

32. Registras Signature 31. Date filed (Month, Day, Year)

2004

28a. Date of Injury (Month, Day Year)



To the Hospital

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

29c. License number

177610

FC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

4a. Facility Name (If not institution, give street and number)

Hos Pital

6. Sex

26

Baltimore

7. Age (In yrs. last birthday)

1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene

4b. City, Town, or Location of Death

Baitimore

If Under 1 Year | If Under 24 Hrs.

repartment of riealth and Menta	ii riygierie	
Certificate of Death	Bac No Z U U	

2. Date of Death

Day

27,

Year

2004

4c. County of Death

Birthplace (State or Foreign Country)
 Unk

white

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

A.AHMED

Year

1X Yes 2 □ No

unk

unk

Z1 Z8 M

Physician
/Medical
Examiner

For State Registra

Sinai

JAMES

5. Social Security Number

**Funeral** Director

filed within 72 hours after death with the Maryland 28a-1 show other treumetic event, the Medical Examiner must be notified at or Items 23e "natural", al Hygiene. 12 should be fill and Mental H Is markad ott permit. Pages 1 and 2.:
Department of Health at
Important: If Itam 27 Is
any injury or other tree

Baltimore, Maryland 21215-0036

UNARES

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit been signed by the should be detached Division of Vital Records, certificate After the funeral within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu

P.O. Box 68760,

8. Date of Birth Oct 16, 1927 Days 1⊠M 2□ F Hours 225-30-2630 76 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 USA 272 S. Broadway Completed by Funeral 12. Was Decedenl Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Uf Yes, Give Year or Dates: unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status unk 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sinai Hospital 2401 W. Belvedere Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 🖔 Other (Specify) in state 21. Signature of Europaid Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Part1. Enter the disease, or composhock, or heart failure. List only of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final avright mia disease or condition resulting in death) Due to (as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initialed events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 1 🗌 Inpatient 2 DER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 T Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (s) and manner as stated. (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signature and title of certifier Mel

DHMH 17 Rev 1/2001

State

Registrar

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore

32. Registrar's Signature

N' Eulaw ST

MAY 1 2 2904

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1 1 L 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Dev Month WILLIAM ALLEN 04 23 AM 29 04 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth MONTGOMERY SILVER SPRING HOME FUREST GLEN NURSING If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Date of Birth (Month, Dey, Yeer) Jan. 5, 1925 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthplace (Stete or Foreign Months North Carolina 1**⊠** M 2□ F 237-34-5102 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Bladensburg 10a. State 10b. County Prince George's MD1⊠Yes 2□No 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20710 5999 Emerson Street, #525 larital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 1943 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Ernest Allen Eya Mae Allen 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, informent's Name/Relationship (Type, Print) Bessie L. Allen - Wife 5999 Emerson St., #525 Bladensburg, MD 20710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Dispos 1 Burial 2 Cromation 3 □Removal from State MD Veterans Cemetery 5/07/04 Cheltenham, MD 5 ther (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Dicense Latney's Funeral Home. . fic. 3831 Georgia Aye., NW, Washington, DC 20011 MND 23a. P. 11. Enter the Assess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or heart value. List only one cause on each line. Approximate Interval Between Onset and Death Stage IIB Gastric Cancer Due to (or as e consequence of): Immediate Cause (Final disease or condition resulting in death) unknown Colow Cancer 20 Years ago Due to (or es e consequence of): 475.490 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last TYM I Diabetes Due to (or es e consequence of): anknown 23b. Did tobacco use contribute to the cause of death? ying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was en autopsy performed? failure

**Physician** /Medical Examiner

attanding physicien end I for usa as the bunel-tren

signed by the a

this

within 24 hours after of To the Funeral Direct completely filled in by

death.

**Physician** 

/Medical

Examiner

Funeral

Director

r than "naturs!, or items 23s or 28s-f show the Medical Examiner must be notified at

ages 1 and 2 should be filed within 72 hours after nt of Health end Mental Hygiene.
If I fem 27 is marked other than "natural; or flei or other traumatic event, the Medical Exercise.

Pages 1

Department of important: If any injury or

Baltimore, Maryland 21215-0036

Director

Funeral

à

Completed

Be

death with the Merylend

Physician/Medical Examiner 2 Completed page 2 s Be Certification: To nersi Director: A

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or Attending Physician: The law requires that the deeth certificate be axecuted

Division of Vital Records, P.O. Box 68760

•	d. Hypertens:
art II. Other significant conditions	contributing to death but not resulting in the underf
	anemia
Car	rdis-respiratory.
5. Was case referred to medical	
examiner?	Hospital:

28e. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At h building, etc. (Spec

24b.	Were autopsy findings available prior to completion of cause of deeth?

1 ☐ Yes	2 100
not only one)	

OI Geetti?	
1 🗆 Yes	2□ No

26. Plece of Dea	th (Check only one)	
r: 4 Nursing H	ome 5 Residence	e 6 □Other (Spe

J	ER/Outpatient	3□ [	JUA	4 LYTHURSING H	iome 5 Hesidence 6 Hother (Specify)
	28b. Time of Injury	М	28c. Injury et Work? 1 ☐ Yes	2 □ No	28d. Describe how injury occurred
	ome, farm, stree	t, facto	ory, office		28f. Location (Street and Number or Rural Route Number City or Town, Stete)

29a.	Certifier (Check only	1 Certifying Physic	ian: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as steted.  : On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause
	one)		end menner steted.

29b.	Signeture	end title of	certifier	
	N .	0	0.	

5 Pending

investigation

6 Could not be determined

29c. License number D43121

Other

29d. Date signed (Month, Dey, Year)

Clowdly, m) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

CHOWDHURT, MD; 5141 KING CHARLES WAY , BETHESDA, MD20819 NURUL

State Registrar

edical

31. Dete filed (Month, Dey, Year)

27. Manner of Death 1 Naturel

2 Accident

3 Suicide

4 ☐ Homicide

MAY 1 2 2004

32. Registrer's Signeture

mode

	•	1 = For Amend Item 23 Registrar	State a per Dr.,C	of Marylar <b>331,0</b> 5/12	od / Depa 2 <b>/04dbb</b> e	artmen <i>rtificati</i>	t of He <i>e of E</i>	ealth a Death	and M	ental Hy	gien Reg. N	e 201	11.	ISACI					
		Decedent's Name (First, Middle)		1						2. Date of De	ath	Can C		3. Time of Death					
Physicia /Medica		Carolyn L. Al	lison							Month April			/ear	8:10 AM					
Examine		4a. Fecility Name (If not institution	, give street and n	u <i>mber)</i>		4b. City,	Town, or	Location of				c. County of	Death	0.10 111					
		Anne Arundel M					apo1				Aı	nne Aı	und	e1					
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs.	. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year		Birthp Coun	lace (State or Foreightry)					
Director	}	216-20-6177 Usual Residence of Decedent		76	115.					Sept 2	4, ]	1927	Mar	yland					
Mo m	Ì	10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside City Limit					
rz nous alle leeen win the Maryland natural', or iteme 23a or 28e-f show disal Evarillat must be notified at	ţō	MD			Balt	imore	2							1X Yes 2 □ N					
128e	iec	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wh	at Coun	itry?					
23a	Funeral Director	806 Washburn A	venue				21	225				USA							
eme	ner	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Deced	ent of His	spanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race -	Americ White,	an Indian,					
P. E.	by Fu	1 Never Married 2 Marri	If Yes, G	2 X No live		1 □ Yes		Specify:			:	Specify:		ite					
i Ex	g p	3 X Widowed 4 □ Divorced  15. Decedent	Year or	Dates:	160 Door	dent's Usua	l Ossuma	tion			105	Clark of Dural							
ene. than "na he Medic	Completed	(Specify only highes	t grade completed		(Give	kind of wor DO NOT us	rk done du se retired)	u <i>ring</i> mos	t of workin	1g	100.1	Kind of Busi	nessinc	lustry					
iene.	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)		semb1					fa	actory	7						
othe vent,	Bec	17. Father's Name (First, Middle,						18. Mothe	er's Name	(First, Middle	, Maide	n Sumame)							
wents rrked rtic e	2	John Go	ellner						Lou	ise We	ilaı	nd							
h and Mental Hygiene. 7 is marked other than ", treumatic event, ITE MED		19a. Informant's Name/Relations								Route Numb	-			Code)					
ealth m 27 ner tr		Sherry Prada/f	riend		_			enue		imore,	_		_						
nent of Health and Mental Hygiene. nnt: if Item 27 is marked other than "natural, or Iteme 23s or 28e-f show ury or other treumatic event, the Medical Examinat must be notified at		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ፟ Donation 5 ☐ Other (S)		1 .	Place of Dispo cemetery, crer	natory or o	ne of ther place	)	Da	ate	20c. L	ocation - Ci	ty or To	wn, State					
Department of Health a importent; if Item 27 is any injury or other treuonce.		21 Signatur: Suneral Service   Ronal d	icensee Warre	Treeto	r St	Name an Late A	\nato	my B	oard 21201	655 W.	Ва	ltimo:	re S	treet					
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea					cardiac or	respiratory a	rrest,	•		Approximate Interval Between					
ıysician		Immediate Cause (Final disease or condition	Carl	11/48							0	Onset and Death							
Medical		resulting in death)		o (or as a consec	quence of):	00								× 7 // ·					
aminer		Sequentially list conditions	bS	epsis															
₩.	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec	quence of):														
and I-tran	Examiner	that initiated events resulting in death) Last	c	o (or as a consec	quence of):														
physician and the burial-transit	E E	,	l bus to	(0) 43 4 0011380	querice or).														
phys s the	dical		d																
or use	0	0	0	Physiclan/Me	ysiclan/Me	ysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live	utcome of pregn birth 2 Fets gnant at time of c nown	al death 3□	Ectopic pro Other (sp						23d. Date of Month		ry Day Year
igned by the s	h h	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying ca	ause giver	n in Part I.		23e. Did t	obacco	use contribu	ute to th	e cause of death?					
po o	d by									1 🗆	Yes 2	100 31	☐ Proba	ably 4 Unknown					
should t	Completed									24a. Was	an	24h We	re autor	osy findings available					
certificate has rector, page 2	mc									auto; perfo	rmed?	prio	or to con th?	npletion of cause of					
or. p		25. Was case referred to medical					···	26 Place	of Doath	1 Yes	2 NO	1 1	Yes	2□ No					
w =	o Be	examiner? 1 ☐ Yes 2,⊠No	Hospital:	Mopatient 2□	ER/Outpatien	it 3□ DO	Othor			e 5 Resid		6 □Other	(Specify	1					
5 = 1	ı;	27. Manner of Death	28a. Date	of Injury nth, Day Year)	28b. Time of		8c. Injury Work?			8d. Describe			арвану	/					
death. ctor: Aft y the fur	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	min, Day Year)	Injury	М		es 2⊡t	No										
after de I Directo d in by th	Certification:	3 Suicide 6 Could r 4 Homicide determi	286. Plac	e of Injury - At h ding, etc. (Speci	iome, farm, str	eet, factory	, office		2	8f. Location (3 City or Tox	Street ar vn, State	nd Number ( e)	or Aural	Route Number,					
	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurred a	at the time in my opi	e, date and inion, deat	d place, ar th occurre	nd due to the d at the time,	cause(s date an	and mann d place, and	er as sta I due to	ated. the cause(s)					
Mithin Fo th	Me	29b. Signature and title of certifier	. 0	-		29c	. License	number			29d. Da	ite signed (/	Month, D	Day, Year)					
		Many =	t. Xua	up		H	00	537	369	7	4/	14/0	4						
		30. Name and address of person	who completed cau	use of death (Iter	m 23a) (Type,	Print	Ne	- A	WIE	vdel	Y	Ne	d.	Ctn.					
Stat	е	31. Date filed (Month Day, Year)		Registrar's Signa	ature	415			IVI			-		-11					
Stat Registra	-	MAY 1 2		Denus &	ature &	So	ak												

Mary Beacham 04-03035 RPD

303	55		- FUI		artment of Health and	Mental Hygie	0001				
			1 - State Registrar	Ce	rtificate of Death		1. No. 2004	15070			
	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month May 4,	2004 Yeer	3. Time of Death			
	/Medic	al.	Mary Lee Beacham  4a. Fecility Name (If not institution, give street and nu-	mher)	4b. City, Town, or Location of De		4c. County of Death	1130 A M			
	Examin	er	Franklin Square Hospital		Rosedale	atti	Baltimore				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H		9. Birthol	ace (State or Foreign			
L	Director		210-24-9735 1□M 2XIF	71 Yrs.	Months Days Hours Mi		1932 West	Virginia			
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10	Od. Inside City Limits			
	Maryl f sho	tor	MD Baltimore	Ess	ex			1 ☐ Yes 2√ No			
	h the	Director	10e. Street and Number		10f. Zip Code	100	. Citizen of What Coun	try?			
	th with		1 Brett Court #221		21221		USA				
	r dea	Funeral	Armed Fo	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Puc	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e				
36	72 hours after death with the Maryland neturel', or terms 23a or 28a-f show Jeal Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Gir 3 🛣 Widowed 4 ☐ Divorced Year or D	2 🔯 No	1 ☐ Yes 2 No Specify:		Specify: Whit	te			
8	in 72 hours "neturel", Lofcal Ex	ted	15. Decedent's Education	16a, Dece	dent's Usual Occupation	16	6b. Kind of Business/Ind	ustry			
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7	be filed withintal Hygiene. Id other then	Completed	12 0		disabled		none				
and		Be	17. Father's Name (First, Middle, Last)  George Shannon Evan	ıs		ame <i>(First, Middle, Ma</i> ary Viola L					
Ž	& P E E	ļ	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or I	-		Code)			
Ma	od 2 Ith a 27 is		Karen Lusby/daughter	17 N	ational Drive Ba	ltimore, M	D 21221				
Je,	iges 1 and of Healt if item 2 or other		20a. Method of Disposition	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City or To	wn, State			
imo	Pages nent of I ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 🕅 Donation 5 ☐ Other (Specify)	State							
Baltimore, Maryland 21215-0036	permit. Pag Department Important: I any injury o		21. Signature of Fineral Service Licensee Ronald S. Wade		Anatomy Boar altimore, MD 212		Baltimore S	treet			
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in 1.									
	Physician	0.1	Immediate Cause (Final disease or condition	Head	Friund			Onset and Death			
	/Medical Examiner		resulting in death)  Due to	(or as a consequence of):	t						
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	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	an an			(or as a consequence of):							
8760,	cate be executed oblysician and the burial-transit	dical	d								
9	death certifica attending pt I for use as tl	/Mec	IF FEMALE: 23c If yes ou	tcome of pregnancy			204 0-4-44-5				
Вох	death certific e attending p ed for use as	clan	in the past 12 months?	oirth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year			
o.	0 0 2	Physiclan/Me	1  Yes 2 No 9 Unknown 9 Unkn		(-)						
S, P	Se 20 0	by P	Part II. Other significant conditions contributing to d	eath but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the				
ord	v require been si should b	ted	or y eversion;	Deary S	mellitus;	1 Tes	202 No 3 ☐ Proba	ably 4 Unknown			
Record	e taw has b	Completed	Cordnery astors	distast		24a. Was an autopsy	prior to com	sy findings available apletion of cause of			
alF						1 Yes 2		2□ No			
Vital		Be c	25. Was case referred to medical examiner?  1X Yes 2 No  Hospital:	Inpatient 2 🖫 ER/Outpatie	Other	eath (Check only one)	ce 6 ☐Other (Specify)	1			
of		n: To	27. Manner of Death 28a. Date	of Injury 28b. Time of		28d. Describe how		)			
ion	Attending Part death.  ector: After to the funeration of the funer	atlo	accident investigation	th, Day Year) Injury	_M 1 Yes 2 No	Subject	f tell				
Division	- i i i	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined build	of Injury - At home, farm, sting, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	et and Number or Rural State)	Route Number,			
	pitel o		29a. Certifier 1 ☐ Certifying Physician: To the	hest of my knowledge, deat	h occurred at the time, date and pla	on and due to the caus	AOCUN	ated			
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medical	(Check only 2 XMedicel Examiner: On the b		h occurred at the time, date and pla vestigation, in my opinion, death oc						
	To th within To th compl	Me	29b. Signature and talle of certifier	^	29c. License number	29d	. Date signed (Month, E	Day, Year)			
)			) ( Lasked		O.C.M.E.	Ма	y 5, 2004				
			30) Name and address of person who completed cause	se of death (Item 23a) (Type,	Print) 111 Penn Street	Raltimore	e Marviland	21201			
		<u> </u>	31. Date filed (Month, Day, Year) 32. F	Registrar's Signatus		, LUITUINIUL	e, miramu	. ~1~\/1			
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			For State	State of Ma	ryland / Depa						
			Registrar		Cei	πiiica	te of Death			g. No.2001	
	Physici	an	Decedent's Name (First, Middle, Las		11/00			2	. Date of Death Month	Day Year	3. Time of Death
	/Medic		Joan Ann	100	KKer			J.	toril_	29,200	4 7:05 AM
	Examin	er	4a. Fecility Name (If not institution, give	street and number)		4b. City	, Town, or Location	6	1	4c. County of De	ath 1
			Mariner tec	ilth		Gle		nie		Anne	Houndel
	Funeral		5. Social Security Number 6. Security Number		(In yrs. last birthday) 8 Yrs.	Months	Days Hours	Min. M	Date of Birth (Month, Day, ay 20,	Year) 5 9. B	irthplace (State or Foreign Country) aryland
	Director		215-30-8866		113.			FI	ay 20,	1933 Ma	iryland
	land		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Mary 1 sh	ŏ	MD Anne Art	ınde1	Glen	Burr	nie				1 □Yes 2 □No
	the 28a	Director	10e. Street and Number			10f. Zi	p Code		10	og. Citizen of What 0	Country?
	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show edical Examinet must be multified at	<u>-</u>	6672 Roberts Cou	ırt			21060			USA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Dece	edent of Hispanic Ori ecify Cuban, Mexicar	igin? (Speci	y Yes or No-		nerican Indian,
9	or Ita	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No					can, etc.)	Black, Wh	
F 8	hours after ural', or Ita	1 by	3 ☐ Widowed 4 🔯 Divorced	If Yes, Give Year or Dates:		1 □ Yes	2X No Specify:			Specify: Wh	ite
5.	72 h	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usu kind of w	ual Occupation ork done during mos	t of working	1	6b. Kind of Busines	s/Industry
~ ~ ~		Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)		use retired)				
$\times$ $\sim$	be filed within tal Hygiene. od other then event, the Meren	S		3	Wa	itre		ata Nama /	=:	restaur	ant
Sokker land 21215-0036	2 a b 2	Be	17. Father's Name (First, Middle, Last)				unk 18. Mothe			aiden Sumame)	
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ર્વ્ય હ	os 1 and of Health item 27 r other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Na	ame of	Dat	9 2	0c. Location - City o	or Town, State
S E	nit. Pages artment of ortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☒ Donation 5 ☐ Other (Specify		cometery, crer	natory or	Oliver prace)				
John Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature Funeral Service Licen	Wade Dire	ctor St	Name a ate 1tim	nd Address of Facilit Anatomy B ore, MD	oard 6 21201	555 W.	Baltimore	Street
			23a. Part1. Enter the disease, or computational street, or heart failure. List only	plications that caused to	he death. Do not ent						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	FRER	ROVAS	SCU	LAR	AC	LINE	NT	Onset and Death
	/Medical		resulting in death)	a. Due to (or as a	consequence of):		1110	1 1	- ( )	-141	114(0)(11)
	Examiner		Sequentially list conditions	ESS	ENTI	71	HYPE	RI	ENS	SION	25 YEARS
	p =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as e	consequence of):		- DULLAGO	A CA D	W Ni	00120	ONEADC
	and trans	am	that initiated events resulting in death) Last	- CITCOINIC	OBSTRUC	IVI	= PULMO	Thist	Y DI	SCAPE	87FAR2
760,	be exician (		Todatily an dodatily Edition	Due to (or as a	consequence of):				(		
87	cate b	dical	•	d							
Box 68	ding I	/Me	IF FEMALE:	23c. If yes, outcome of	f pregnancy						8
Во	atten for us	lan	in the past 12 mooths?	1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic p	regnancy			23d. Date of de Month	elivery Day Year
P.O.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	1 □ Yes 2 █ No 9 □ Unknown	9□Unknown	me or dealin 5	J Other (S	респу)				
	lhat ( ed b) deta	F.	Part IL Other significant conditions co	ontributing to death but	not resulting in the u	nderlying	cause given in Part f.		23e. Did toba	acce use contribute	to the cause of death?
sp	uires sign ld be	d by	PSORIAS	21					1 10	2 No 3 F	Probably 4 Unknown
0	w req beer shou	Completed							24a. Was an	24b Were a	autopsy findings available
R.	he la b has ge 2	m d							autopsy	ed2 prior to death?	completion of cause of
<u> </u>	ficate or, pa	e Cc	25. Was case referred to medical					. ~			s 2 No
Ξ	sician: The law s certificate has b irector, page 2 si	80	evaminer?	Hospital:	t 2 ER/Outpatien	+ 2CLD	Other		heck only one	nce 6 Other (Spi	
<b>o</b>	Phy ar this aral d	J: To	27. Manner of Death	28a. Date of Injury (Month, Day			28c. Injury at			v injury occurred	90119/
o.	nding ith: :: Afte	t lo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	Year) Injury	м	Work? 1 ☐ Yes 2 ☐ I	No			
Division of Vital Records,	r Atta	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	y - At home, farm, str	eet, factor	y, office	28f	Location (Stre		Rural Route Number,
Ö	To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page:		29a. Certifier 1 Certifying Ph	ysician: To the best of		occurred	I at the time, date an	d place, and			as stated
	he Hos in 24 h ihe Fur pletely	Medical	(Check only 2   Medicel Exem	iner: On the basis of e	examination and/or inv	estigation	n, in my opinion, dea	th occurred	at the time, da	e and place, and du	e to the cause(s)
	To To	2	29b. Signature about the of pertition	In M	1	29	c. License number	CD.	A P	d. Date signed (Mon	th. Day, Year)
			led NA- All the control of	iomoldied adult - und	Un 1000 0201 5	Bdc+C	Δ Λ · · · ·	71 <u>1</u> 1	FILE	TIMA	7
			The Bo soless of berson and	C. M. C.	th frem 23a) Type		TIMORE	, MA	FRYL	ANED 2	(325)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	In	No.		(		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5:30 **Physician** 09 2004 ам May Bradyhouse Beatrice M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A Joseph Ritchie House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 0ct. 23, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Months 1 □ M 2 1 F 80 Mary land Yrs. 213-20-9362 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28e-1 show other treumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No Md. Baltimore Catonsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 715 Maiden Choice Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Typist Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is marked othn any injury or other treumatic event 2008. Be Ethe1 Ε. Parlett Bradyhouse, Jr. Richard G. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 York Rd. Suite 110 Lutherville, Md. 21093 Mr. Jeffrey F. Higdon/ Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cem. 5-13-04 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RUCK Towson, Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licensee / 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAS Pnysician disease or condition resulting in death) /Medical Di to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Judanying Cause (Disease or injury Due to (or as a consequence of): Examine the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 1∐ Yes 2🞣 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) HOSPIC Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🙀 No 28a. Date of Injury (Month, Day Year) 27. Manner of Seath 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: or Attending 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours eft To the Funerel Di completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - ANANDA KNISHNAN 821

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) MAY 1 2 201

ORIGINAL

32. Registrar's Signature

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	44.5					Ce	rtifica	e of	Death		Reg. No.	2004	-	073
	Dhusinian		1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	Day	Year	3. Time	of Death
-	Physiciar /Medica		William S. B	rucker						May	9, 20	304		30 AM
	Examine		4a Facility Name (If not institution, giv	e street and number)					4b. City, Town, or L			County of Death		
			Stella Maris			4.4	if Hode	r 1 Year	Timonium			3altimo:		
B	Funeral Director		210 12 0007	7. Age	(In yrs. last	Yrs.	Months		Hours Min.	8. Date of Bir (Month, Da Dec. 2	$\frac{10}{24}$ , $\frac{10}{19}$	9. Birth Cou 1	place (State intry) ndiana	or Foreign
	pue *	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or L	ocation						10d. Inside (	City Limits
	Aaryle f sho	5	MD Baltim	ore	Tow	200							1 □ Ye	s 2 📉 No
	the 288	Director	10e. Street and Number	OLC	100	3011	10f. Zi	Code			10g. Citize	en of What Cou	intry?	
	Sa or	5	1500 Providence	Road			2	1286			Uni	ited Sta	ates	
	death	Funerai	11. Marital Status	12. Was Decedent E	ver in U,S.	13.			Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		4. Race - Ameri	ican Indian,	
020			1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 DXYes 2 No lf Yes, Give Year or Dates:	∘WW II	-	1 ☐ Yes			o Alban, etc.)		Black, White, Specify: Wh		
2-0	72 ho	Completed by	15. Decedent's Ed (Specify only highest gre	ducation	1	6a. Dece	edent's Usu	al Occup	pation during most of world	kina	16b. Kind	d of Business/Ir	ndustry	
21	thin 7	ᇍ	Elementary/Secondary (0-12)	College (1-4or 5-	+)				during most of work d)	ung.				
2	ad wi	5		5+		Eng	ginee	r		(F) . 10:11		ngineeri	ing	
P P	tal H	9	17. Father's Name (First, Middle, Last)						18. Mother's Nam			iurname)		
3	2 should be financial Mental His marked of reumatic every	9		ucker		405 A4-11	A .I.I	- (Са	Anna Land Number or Ru		ers	Town State 7	in Condo)	
, Mal	and 2 sh eaith and n 27 is n		19a. Informant's Name/Relationship ( Beulah Brucker/			150	00 Pr	ovid	ence Roac	d Towsc	ın, ME	21286	6	
Baltimore, Maryland 21215-0020	Peges 1 nent of He int: If Itan		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cem	etery, cre	osition (Na ematory or SVC •	other pla		Date 5/10/200		ation - City or T		
Balti	parmit. Pege Depertment of Important: If any injury or pnce.	1	21. Signature of Funeral Service Licer			2	2. Name a	nd Addre	ess of Facility	Ruck Tou	son f	Funeral and 21:	Home,	, Inc.
		-	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death I	- 1				,	,		Approxima	ate
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	a. ESOPHAGE		NCER	<u>.</u>					- 1	Interval Be Onset and	d Death
ć,	physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as	a conse	quence of)	:						
ox 68760,	E 00	/Medical	Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (or as	a conse	quence of)							
Box	attar d for u		Part II. Other significant conditions of	ontributing to death bu	t not resultin	a in the	underlying	rause di	ven in Part I	23h Did	tobacco u	use contribute t	to the cause	of death?
P.O.	d by the	Physician	Pan II. Other significant conditions of	ontributing to death bu	it not resultir	ig in the t	undenying	cause gr	venin raiti.			No 3□ Pro		Unknown
of Vital Records,	The law requires that the death ce ate hes been signed by the attendings 2 should be detached for use	Completed by								24a. Was	an autops ormed?	av co	Vere autopsy vailable prior ompletion of f death?	rto
æ	ysician: The law is certificate hes director, paga 2	Ş								1.0	Yes 2X	No 1	□Yes 20	□ No
ïta	den:	e e	25. Was case referred to medical examiner?						26. Place of Dea	th (Check only	one)			
Ž	Physician: this certific iral director,	0	1 ☐ Yes 2 X No	Hospital: 1  Inpatier		/Outpatie		UA				Cother (Speci	(by) HO	SPICE
L	ng Pl	6	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28	b. Time o		28c. Inju Wo		28d. Describe	how injury	occurred		
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e co- Disea of Isin	iry - At home	, farm, s	M treet, facto		Yes 2□No	28f. Location ( City or To		Number or Rur	al Route Nu	ımber,
Ö	pital or ours afte eral Dir filled in	Se	29a. Certifier 1X Certifying Ph	ysician: To the best of		dge, dea	th occurred	at the ti	me, date and plece	end due to the	cause(s) a	and manner as	stated.	
	Fur letely	edical		niner: On the basis of and manner stat	examination									)(s)
_	To the Hospital Within 24 hours To the Funeral completely filled	E	29b. Signature and title of certifier				29	c. Licen:	se number		29d. Date	signed (Month,	Day, Yeer)	
	1			1-				Di	13725		3	5/10/0	04	
	241	1	30. Neme and address of person who	completed cause of de	eath (Item 23	Ba) (Type	, Print)					/ /		
_	200		DR. TARIQ MAHMOO				LEY R	D.	TIMONIUM,	MD 210	93	<u> </u>		
	State	е	31. Date filed (Month, Pay Year) 004	Registre	er's Signatur	4	Spor	K	,					

WILLIAM BRUCKER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Sister M. Gerald Blakeley O.S.F. MAY 2004 4:00 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore lowson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 0 (Month 2 Say, 1794) 5 9. Birthplace (State or Foreign Mary) and 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F 88 207-40-8603 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Towson Baltimore Md. Director 10g. Citizen of What Country? USA 10f. Zip Code 21204 10e. Street and Number 7601 Osler Drive or Items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced natural Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher Ith and Mental Hygie 27 Is marked other r traumatic avant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elizabeth Marie Smyth Berlin Blakeley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7601 Osler Dr. Towson, Md. 21204 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If itam 27 is y or other train Sister Margaret St. John 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1★ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Department of Important: If any injury or once. Our Lady Of Angel Cemi.5-11-04 Aston, Pa. 4 □ Donation 5 □ Other (Specify) Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fyneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ABDOMINAL AORTIC ANEURYSM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) 4 ☐ Pregnant at time of death ed by the a 9 Unknown been signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown ACUTE RENAL FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2X□ No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760, Records. Division of Vital Hospital or Attanding Physician: To the Hospital or Attandin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

Baltimore, Maryland 21215-0036

Medical State Registrar

<u>FRANCIS KHOO.</u> 31. Date filed (Month, Day, Year) MAY 1 2 2004

29b. Signature and title of certifier

7601 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D

OSLER DRIVE. TOWSON, MARYLAND 21204

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D3Ø263

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robyn Lynn Baginski Unpend Item #253227 Maryland (3592 1879) but Health and Mental Hygien [] [] ! 04-03044 For U State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Vear May 4, 2004 1010 P.M Robyn Lynn Baginski /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Agnes Hospital Baltimore N/A5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 💥 🖾 F Days Hours Yrs. 213-64-8305 Director 49 May 20,1954 Maryland Usual Residence of Decedent Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shoy traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 United States 24 1/2 Dunvegan Road Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☐xNo Specify White 3 ☐ Widowed 44 Tx Divorced "neturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nursing 3 Years Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis A. Martin Ida K. Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 373 Cool Breeze Ct. Mrs. Mary Bandorick /Sister Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of I Department of Important: If it any injury or o txxBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ② Other (Specify) Crestlawn Cemetery 5/7/2004 Marriottsville, MD 21. Signature of Americal Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fiper Physician disease or condition resulting in death) Seizure disorder /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day signed by the at id be detached for 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 □ No 24a Was an 2 No Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death eck n one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1X Yes 2 □ No XXER/Outpatient 3 DOA 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide after within 24 hours a

To the Funerel (
completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number C.M.E. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)
May 5, 2004 30. Name and address of pers completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 2 2004

		1	For State Registrar	State of Maryl	land / Depa <i>Cer</i> i	rtment of He	ealth and Me Death	ental Hygie		15076
	Physicia	ın	1. Decedent's Name (First, Middle, Las	it) /	Ro	10010		2. Date of Death Month	Day Year/	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, give	e street and number)	ي و	4b. City, Town, or	Location of Death	1174 5	4c. County of Death	6:11P M
	Examin	er	BALL MURE VA	MediCAL	CONTOR	BA	Himore	,	MA	
	Funeral Director		5. Social Security Number 6. S 2 1 2 - 4 4 - 3 4 1 8	ex 7. Age (In	yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Sept . 6 ,	9. Birth 1946 Mai	nplace (State or Foreign untry) Cyland
	and and		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Loc	ation				10d. Inside City Limits
	the Marylar 28a-f show	tor	M.D. N/A	\ I	Baltimon	re				1X Yes 2 □ No
	ith with the 23a or 28. ust be not	i Director	10e. Street and Number 2314 W. Lanvale	Street		10f. Zip Code 2121	7	10g.	. Citizen of What Co	untry?
36	after dea or Items	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🏋 Divorced	12. Was Decedent Ever Armed Forces? 1. ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	lf lf	/as Decedent of His Yes, specify Cubar ☐ Yes 2☐xNo	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Amer Black, White Specify: Bla	e, etc.
5-0036	"natural",		15. Decedent's Education (Specify only highest gra	ducation	16a. Deced	ent's Usual Occupa	ition uring most of working	168	b. Kind of Business/l	ndustry
2	C 2	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired,	)			ceel
d 21	filed within Hygiene. other than " ent, ine he		12th 17. Father's Name (First, Middle, Last,			Foreman	18. Mother's Name	(First, Middle, Mai	Compar	ıy
lan	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Menmatic event ev	To Be	William Lindsay	Beverley	, Sr.		Lois B	ranch		
Maryland	ges 1 and 2 should be filed within to of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, Ite Me		19a. Informant's Name/Relationship (						tity or Town, State, Z	
	Health tem 27 other tra		Lois M. Beverle 20a. Method of Disposition	20	0b. Place of Dispos	sition (Name of	Di		M.D. 212 c. Location - City or	
MO	Pages nent of h ant: If its ary or o		1		Garrisor	atory or other place n Forest	5/12	/2004 O	wings Mi	lls,M.D.
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr QRGE.		21. Signature of Funeral Arvio Lic-	Emy A					eral Homalto.,M,	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications hat caused the one cause on each line						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		veamo,	VA				
	Examiner			Due to (or as a con	nsequence or):					
	sit ad	iner	Sequentially list conditions, if any leading to in additionable cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	use meuce of).					
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9	leath certifica attending ph	/Med	IF FEMALE:	23c. If yes, outcome of pr	regnancy				23d. Date of deli	
O. Box	that the death cer ed by the attendir detached for use	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
rds, P	quires that the signed by	d by Pł	Part II. Other significant conditions of ChRon/& D	contributing to death but no	0.1				cco use contribute to	
of Vital Records,	The law requires that the death certificate be executed take as been signed by the attending physician and take as been signed by the attending by schould be detached for use as the burial-transit	Completed	Squamous	CALL	CARLIN	om A of	the Neck	24a. Was an autopsy performer 1 Yes 2	d? prior to death?	topsy findings available completion of cause of
/ita	cian: sertifica ector, I	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death			
	Physic r this or sral dir	); To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	28c. Injury	at 2	ne 5 Residence 8d. Describe how	ee 6 □Other (Specinjury occurred	ify)
ion	ath. ath. or: Afte	ation	1 Natural 5 Pending investigation		a <i>r)</i> Injury	M 1 🗆 '	rr Yes 2 □ No			
Division	or Atteriter de Directo in by th	Certification;	3 Suicide 6 Could not be determined		At home, farm, stre	eet, factory, office	2	Bf. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
J	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical Ce		nysician: To the best of my niner: On the basis of exa and manner stated.	amination and/or inv					
	To the within (	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	number	29d	. Date signed (Mont)	n, Day, Year)
)			13C1	Mr M	is	PI	7650		5-5-4	
	10x,		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) REENE.	5thert L	BACTINA	RAMD &	2/20/
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 2	32. Registrar's :	Signature	4 Spa	1650 Street 1			

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			1 - For State Registrar		State o	f Marylar	-			lealth a	and M		Reg. No. 2	00		5078
	o Physici	an	1. Decedent's Name (First, M		99 1		D					2. Date of De Month	Day	Yes	ar	e of Death
	/Medic	al	Aleene 4a. Facility Name (If not institu		ollard	m harl	Bre	wer	Town	r Location o	of Dooth	May	/ 4c Co	unty of D	004 12:	12 p '''
	Examin	ier	Kris Leigh						mbri]		n Death				undel	
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday	) If Unde	r 1 Year	If Under		8. Date of Bir (Month, Da			Birthplace (Sta Country)	ite or Foreign
	Funeral Director		577-24-4632 Usual Residence of Deceden		M 2 <b>∑</b> F	82	Yrs.	Months	Days	Hours	Min.	Oct. 1	9, 192	21 W	Country) lashing	ton, DO
	yland		10a. State 10b. Co.	nty		10c. C	ity, Town or L	ocation								e City Limits
	a-fs	ctor	MD Ann	e Arui	ndel		Crofto	n							10	Yes 2∏ No
	or 28	Director	10e. Street and Number					10f. Z	p Code				10g. Citizer	of What	Country?	
	ath w	rai	2011 Aberde						211	<u> </u>			US			
	ltems	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ i		2. Was Dec Armed Fo 1 ☐ Yes		J.S. 13.	If Yes, sp	edent of H ecify Cuba	lispanic Origin, Mexican	gin? (Spi n, Puerto	ecify Yes or No Rican, etc.)	)-   14.		merican Indiar /hite, etc.	1,
000	Ir, or	by	Widowed 4 Divol		If Yes, Gi	ve		1 🗆 Yes	XXNo	Specify:			Sp	ecity:	White	e
5	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or ltems 23a or 28a-f show unatic event, the Mudical Exempliar most lex notified at	ted	15. Dece	dent's Educ	ation		16a. Dec	edent's Us	ual Occup	ation			16b. Kind	of Busine	ss/Industry	-
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ylalla	be file tal Hy d oth	Be	17. Father's Name (First, Mid							18. Mothe	er's Name	a (First, Middle	, Maiden Su	mame)		
<u>8</u>	Men Men arke	2	William O.									1. Evans	-			
Ma	2 sh and Is rr raum		19a. Informant's Name/Relat		. ,							al Route Numb				
ນົ	1 and Health		Marth Evans 20a. Method of Disposition	(Daug	gnter)	20b.						Taylor			or Town, State	
2	ages or of p		XX Burial 2 □ Cremat		emoval from	State	Place of Disp cemetery, cre									
pallilliore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Mudical Externing Internal Legisla 1 and 2006.		' 4 ☐ Donation 5 ☐ Other			Na	tional			ss of Facilit		2004	Falls	Chu	rch, V	7
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ב ב	The law re ate has bee page 2 sho	Completed							-			24a. Was autor perfo		4b. Were prior death		igs available of cause of
2	ician: Th certificate rector, pag	Be	25. Was case referred to me examiner?								of Death	n (Check only o	one)		Ass	sted
5	Physician: rthis certific ral director,	၉	1 Yes 2 No	- П		· ·	ER/Outpatie			4 🗆 190		me 5 Resi			ipecity) Z N	NH
=	fte ne	lon	27. Manner of Death 1   Natural 5 □ Pe		(Mor	of Injury th, Day Year)	28b. Time	M	28c. Injur	yat k? Yes 2 ⊟≀		28d. Describe I	now injury o	ccurred		
JIVISION	or Attending after death. Director: After in by the fune	ertification:	3 □ Suicide 6 □ Co	estigation uld not be ermined	28e. Place build	of Injury - At hing, etc. (Speci	nome, farm, s			105 2 1		28f. Location (S City or Tox	Street and N wn, State)	umber or	Rural Route N	lumber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier Cert (Check only 2 Med	fying Phys cal Examir	ier: On the b	best of my kn asis of examin ner stated.	owledge, dea ation and/or i	th occurred	d at the tin	ne, date and pinion, deal	d place, th occurr	and due to the red at the time,	cause(s) and date and pla	d manner	as stated, due to the caus	se(s)
	To th within To the compl	Me	29b. Signature and title of ce	tifier				29	c. Licens	e number			29d. Date s	gned (Mo	onth, Day, Yea	r)
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	1,0		30. Name and address of per	son who co	mpleted cau	se <del>of death</del> (Ne	m 23a) (Type	, Print)				/	, ,00	/ 6	-;	
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*/	Sta Registi		31. Date filed (Month, Day, Y	ear)	32. F	Registrar's Sign	ature	for	مرد با	, +			,			

			For Stete	State of Mary		artment of Health a		211111	15079
			Registrar  1. Decedent's Name (First, Middle,	Last)		uncate of Death	2. Date of De	_	3. Time of Death
	Physicia /Medic		Max well	L. Ba	ron		May	8 200	10:45H.M
	Examin		4a. Facility Name (If not institution,	1 1		4b. City, Town, or Location of	of Death	4c. County of Deat	
	Funeral	3	5. Social Security Number		yrs. last birthday)	If Under 1 Year If Under		BAUTI (	nplace (State of Foreign
ь	Director		277-03-7959	1 <b>X</b> M 2□ F	90 Yrs.	Months Days Hours	Min. (Month, Da	5-1913 Dec	WYORK.
	and and I		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryl I sho	tor	dm dm		BALT	IMORE			1 Yes 2 □ No
	or 28g	Olrec	10e. Street and Number	. 0,		10f. Zip Code		10g. Citizen of What Co	untry?
	sath w	Funeral Director		naries St.	in U.S. 13	21218 Was Decedent of Hispanic Ori	gin? (Specify Yes or No	14. Race - Ame	rican Indian,
(0	r Itam Inner	Fune	11. Marital Status  1 Never Married 2 Marrie	Armed Forces?	1	Was Decedent of Hispanic Original (Mass)  National (Mass)  National (Mass)  National (Mass)	, Puerto Rican, etc.)	Black, White	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ta M. Jical Excriter must be rutified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:				Specify: W	7,40.
15-(	n 72 h n "natu	Completed	15. Decedent' (Specify only highest	grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	t of working	BALTIMO R	•
2121	filed withi Hygiene. Ither than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Self	Employed		DISPLAY -	INDUSTRY
	be filed tal Hygi d other evant, I	Be	17. Father's Name (First, Middle, L	ast)		$\mathcal{L}$	er's Name (First, Middle,	, Maiden Sumame) <sup>*</sup>	•
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, it a Macing Examinating the rolling at any injury or other traumatic event, it a Macing.	P.	19a, Informant's Name/Relationsh	io (Type, Print)	19b. Maili	ng Address (Street and Number	Se Dural or or Rural Route Number	er, City or Town, State, 2	Tip Code) 11212
Ma	nd 2 sho alth and 27 Is m ir traum	i	Julie Car		344	Homeland	Southwa		re MD
ore,	es 1 and 3 of Health fitam 27 r other tr		20a. Method of Disposition 1 Burial 2 Cremation	3 DRamoval from State	Ob. Place of Dispo cemetery, crea	matopy or other place)	Date	LOc. Location - City or	Town, State
Baltimore	permit. Pag Department Important: I any injury o		'4 □Donation 5 □ Other (Sp	ecify)	UALUS FIN	DERALCHAMEL	5-10-04	Forest Hi	II, mD
Bal	permit Depar Impor any in		21. Signature of Funeral Service L	icensee Za lasta	$\mathcal{O}_{\mathcal{C}}^{2i}$	2. Name and Address of Facility  ACEFUL ALTER	12325 YOU	K KD TIMON	DEMATION
	.#V		23a. Part1. Enter the disease, dr	complications that caused the only one cause on each line.	death. Do not en	ter the mode of dying, such as	cardiac or respiratory a	rrest, MD 2109	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	recurr	_	piration pne	eummia		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a co		0 1:00/			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (ur as a co	onsequence of):	enl dyspha	5.4		wells
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. mult.	isle stra	res			weeks
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687	ficate to physical street.	edical		d					
Box (	death certifica e attending ph ed for use as th	m/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		∃Ectopic pregnancy		23d. Date of del	
	e deat the atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time		Other (specify)		Month	Day Year
P.0	vrequires that the debeen signed by the should be detached	/ Ph	Part II. Other significant condition	ns contributing to death but n	ot resulting in the u	inderlying cause given in Part I	. 23e. Did t	obacco use contribute Ic	the cause of death?
rds,	quires n sign uld be	ed by	chronic ven	al Sailure			10	Yes 2 No 3 □ Pr	obably 4 □Unknown
Records,	a SS	Completed	prostate ca	nceR			24a. Was	psv prior to o	topsy findings available completion of cause of
H H	Th ate pag	Com	,				perfo	ormed? death? 2XNo 1 ☐ Yes	2□ No
of Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	Others	of Death (Check only oursing Home 5 - Resi	one) dence 6 <b>X</b> Other (Spe	M. H. spice
of		n: To	27. Manner of Death	28a. Date of Injury	28b. Time o			how injury occurred	3.19) (1 0 2   1 0 2
sior	Attanding F r death. ector: After by the funer	catlo	1 Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ation		M 1 Yes 2			Deute Northern
Division	or Att	Certification:	4 Homicide determ		- At home, farm, st Specify)	reet, factory, office	City or To	Street and Number or Ru wn, State)	irai Houte Number,
_	spital hours inaral y filled	aC				th occurred at the time, date ar			
	To the Hospital or Attand within 24 hours after death To the Funaral Director: completely filled in by the	Medical	one)	and manner stated		nvestigation, in my opinion, dea	ith occurred at the time,		
	To To Con	2	29b. Signature and title of certified	1 10	ممم	29c. License number		29d. Date signed (Month	2
	7		30. Name and address of person	who completed cause of beat	h (Item 23a) (Type			/ -/	
			W. A. Riley	GBMC 67	01 N.	Charles St.	Balts. m	1 2120,	k 
		ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	parks			
	Regist	rar	MAY 1 2 200	1	1 1	11.3571			

			State of Maryland / Department of Health and N  1- State Registrar Certificate of Death		ene2004 15080
			Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physici /Medic		GRACIE B. BARNES	Month	Day Acory 927 PM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death
			Sinai Itospital of Baltimare Battimer Cit	7	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, )	9. Birthplace (State or Foreign Country)
	Director		241-68-3848	10-7-19	923   GEORGIA
	show		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	a-fst	tor	MD. N/A BALTIMORE		1 <mark>X</mark> ☐Yes 2 ☐ No
	or 28	Director	10e. Street and Number 10f. Zip Code	109	g. Citizen of What Country?
	ath wi		2654 PARK HEIGHTS TERRACE 21215		USA
	er de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14 Marital Status)  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent of Hispanic Origin? (Sp. 15 Marital Status)	ecify Yes or No- Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
50	rs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		Specify: BLACK
12-003p	be filed within 72 hours atter death with the Maryland tal Hygiene. d other than "natural", or Itama 23a or 28a-f show event, I're Medical Examinar must be multied at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	. 16	6b. Kind of Business/Industry
2 2	I within 72 ho liene. r than "natur It e Medical	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	ung	
7	ygien Ygien t, Its	Completed	-120- PARENTING		FOSTERCARE
Maryland	buld be filed with Mental Hygiene arked other that atic evant, It of	Be		e (First, Middle, Ma	
2	d 2 should be th and Menta 7 Is marked traumatic ev	ို	JAMES B. WILLIAMS  19a. Informant's Name/Relationship (Type, Print)  19b. Maifing Address (Street and Number or Run	NIE NORRI	
<u> </u>	12 s h ar 7 ls trau		HAZEL C. BARNES (DAUGHTER)  4228 PIMLICO RD. BALT		
ā,	s 1 and f Health item 27 other tr		20a Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or Town, State
Ē	00		1 QBuriai 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)  CARRISON FOREST VETERANS		TINGS MILLS, MARYLAND
Baitimore,	permit. Page Department Important: If any injury o		21. Signal uneral Service Liceosee JONATH N D. HIBNER. Name and Address of Facility PHI		
ñ	F 5 F 8	[ j	Jonatha O. FiBre 1721-27 N. MONROE S	T. BALTIM	ORE, MARYLAND 21217
			23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shopk, or heart failure. List only one cause on each fine.	or respiratory arres	Interval Between
	Priysician	(i)	Immediate Cause (Final disease or condition  Mocardial Intertion		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		
	LXGIIIIICI	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	nsit	nine	cause. Enter Underlying Cause (Disease or injury		
,	execu in and ial-tra	Examiner	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):		
/60	The law requires that the death centificate be executed tite has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dical	d		
200	ng ph	Med	IF FEMALE:		
ROX	leath certific attending p	lan/I	23b. Was decedent pregnant in the past 13 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
	t the dea by the a tached f	Physician/Me	1 Yes 2 No 9 Unknown 5 Other (specify)		
٦.	that the	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
g Q	w requires that been signed E should be delt	d by		1 ☐ Yes	2 No 3 Probably ↓ Unknown
<b>Hecords</b> ,	w req	lete		24a. Was an	24b. Were autopsy findings available
	The taw cate has page 2:	Completed		autopsy performe	prior to completion of cause of death?  Yes 2 No
Vital		BeC	25. Was case referred to medical examiner? 26. Place of Deat	h (Check only one)	12,00
	d is	To	Hospital:	ome 5 Residen	ce 6 Other (Specify)
Ē	Viter t	on:	1. Naturaf 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred
Division of	trand death tor: /	cat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined experiment	28f Location /Stra	et and Number or Rural Route Number,
$\leq$	after a	Certification;	4 Homicide determined building, etc. (Specify)	City or Town,	
_	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cau	se(s) and manner as stated.
	n 24 h n 24 h ha Fu	Medical	(Check only and manner stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrant manner stated.	red at the time, date	and place, and due to the cause(s)
	To the within To the comp	Σ	29b. Signature and title of certifier 29c. License number	290	I. Date signed (Month, Day, Year)
	1		D0058910		May 8, 2004
	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Leah Wendell MD. Sinai Hospital 2401 W. Behede	10 Ho R	Mass MD
	Sta	10	Jean Wendell MD. Sina, Hospital 2401 W. Behede 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1912. JU	THE THE STATE OF T
	Registi		Jean Wendell MD. Sinai Hospital 2401 W. Behevel 31. Date filed (Month, Day, Year)  MAY 1 2 2004  MAY 1 2 2004		
			A constant		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 908 AM **Physician** Barnes illie May 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N Baltimore HOPKINS Bayview JOHNS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 241-64-5569 1 □ M 200 F Months Days Hours Yrs Vovember 30,1939 Director Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 27 is marked other then "neturel", or items 23e or 28e-1 show treumetic event, the Medical Examinar must be mutified at 1 Yes 2 No Completed by Funeral Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Importent: If tiem 27 ie marked other then "neturel", or Items 23e or 2 any injury or other treumetic event, Ille Medical Examinas must have 21206 USA Shamrock Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HouseKeeping Church 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Pauline Moore Harr ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4784 Shamrock Avenue Baltimore MD 21206 Janet Harri 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) rbutus MemorialPK 5-14-04 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Eacility
HGV, P. Close Funency Service, P.A.
209 Tessier St., Battinone, MD 21201 21. Signature of Funera Service License ssier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial infarction Physician unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Artery ronary Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a conseque Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): led by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 2 | Fetal death 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Onknown failure 1 ☐ Yes 2 ☐ No Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

Dilks

29b. Signature and title of certifier

Medical Resident

29c. License number RESIDDD

MD DIZZY

29d. Date signed (Month, Day, Year)

May 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue Allidon

31. Date filed (Month, Day, Year)
MAY 1 2 2004

32 Registrar's Signature

Diller at a t		1. Decedent's Name (First, Middle	, Last)							2. Date of De			, ,	3. Time of Dea
Physicia			Benny	Ben-	amin	Bro	own	III		Month May 5	Day 20	у Ү 004	ear ear	2205
/Medic		4a. Facility Name (If not institution,			i din Lii			Location o	of Death	May J		. County of	Death	
LAGIIIII	ICI	2701 W. Lauret	ta Avenue			Bal	timo	re						
Funeral			6. Sex 7	Age (In yrs. I	ast birthday)	If Under	1 Year	If Under:		8. Date of Bir (Month, Da	rth	9	Birthpl	ace (State or Fo
Director		220-38-5057	XXM 2□F	59	Yrs.	Months	Days	Hours	Min.	5-26			Count	Md
		Usual Residence of Decedent												
how	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside City L
g-ga-L	5	Md	N/A	F	Baltimo	ore								1 Yes 2
Department of Health and Mental Hygiene. Important: If item 27a or 28a-f show Important: If item 27 ie marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Exeminer must be notified at once.	Director	10e. Street and Number 2701 Lauretta A	Avenue			10f. Zip	Code 21223	3				tizen of Wh USA		ry?
ns 23	Completed by Funeral	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13. V	Vas Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No	D-	14. Race -	America	an Indian,
rter	F	1 Never Married 2 Marri	Armed Force ed 1 ☐ Yes 2 [		l li	Yes, spec	fy Cuban	i, Mexican	, Puerto l	Rican, etc.)		Black,	White, e	tc.
0, 9	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date:	s:	1	I□ Yes 2	XNo	Specify:				Specify:	B1a	ıck
natur cet	ted	15. Decedent (Specify only highes	's Education		16a. Deced	lent's Usua	Occupat	tion	t of workir	na	16b. K	ind of Busi	ness/Ind	ustry
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al Hy	Be (	17. Father's Name (First, Middle, I						18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)	•	
Ment arkec atic a	10	Benny Benjami	in Brown, I	Ι				Loui	se O	wens				
and le ma		19a. Informant's Name/Relationsh								l Route Numb				Code)
ealth n 27 ner tr		Naomi Brown	ı – wile	- I		Stor				Balto,		2123		
of H if iter	. 1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from Sta	te 20b. Pt	lace of Dispos emetery, cren	sition (Nam natory or ot	e of her place	)	D	ate	20c. Lo	ocation - Ci	ity or Tov	vn, State
ant:		'4 □Donation 5 □ Other (Sp		Ki	ng Men	noria1	. Par	:k ∫5	/11/	2004	Rat	ndall	stow	n, Md
port port y inj		21. Signature of Funeral Service I	icensee		22	. Name and				rch F/I		est		
0 E E B	10 9	Ettline (	e. Tho	morgan	2		43	300	Waba	sh Ave	nue 1	Balto	, Md	21215
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** April 28, 2004 1:50 PM M Doris E. Cooper /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Arbutus 5504 Sycamore Avenue If Under 1 Year | If Under 24 Hrs. | Hours | Min. 8. Date of Birth (Month, Day, Year) Mar 24, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 💢 F Yrs. 81 215-14-5997 1923 Maryland Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 7 is marked other than "netural", or Itema 23s or 28s-f show traumatic event, the Medical Examinar most be incilled at MD 1 ☐ Yes 2√ No Baltimore Arbutus Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5504 Sycamore Avenue 21227 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White Baltimore, Maryland 21215-0036 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: if item 27 is marked other than eny injury or other traumatin secretary insurance bonding 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Frederick Engles Mary Ethel Hunt ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Siffrin/daughter 5504 Sycamore Avenue Arbutus, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Kona d S. Wade State Anatomy Board 655 W. Baltimore Street mon Baltimore, MD 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) SPIRATION NEUMONIA **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by DISEASE page 2 should be BSTRUCTIVE RONIC 1 ☐ Yes 2 ☐ No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?/ Yes 2 No 2□ No certificate 1 Yes 1 Tyes After this certification funeral director, p or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification; To 1 Tyes 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident completely filled in by the 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier Jecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alluan D28595 sucelle

State Registrar 31. Date filed (Month, Day, Year)
MAY 1 2 2004

ASNEEM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKHANI,

32. Registrar's Signature

7220

			State of Mai	-	artment of Health and Natificate of Death	Mental Hygier	ne No.2004	5084
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Tin	ne of Death
	Physicia /Medic		Ralph G. Crawson					53 P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
			346 Shetlands Square		Glen Burnie		Anne Arundel	
	Funeral		18714 OCT	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (St Country)	tate or Foreign
١.,	Director		220-30-0034	70 Yrs.		Dec. 30, 1	933 Florida	
	and w		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	ocation		10d. Insid	de City Limits
	Aaryli sho	٠	Maryland Anne Arundel	Glen Burn	nie		10	Yes 2∏No
	28a-	ect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?	
	with 3a or	١٥	346 Shetlands Square		21061	IIn	ited States	
	ns 2	Funeral Director	11 Marital Status 12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American India	an,
9	or ite	교	1 Never Married 2 Married 1 X Yes 2 No		I Yes, specify Cuban, Mexican, Puero	o rican, etc.)	Black, White, etc.	
21215-0036	within 72 hours after death with the Maryland one. Than "natural", or items 23a or 28a-f show the Marylad Examiner most be matified at	l by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: C	onflict	Tip res 24a No Specify.		Specify: White	
5-0	72 h	Completed	<ol> <li>Decedent's Education (Specify only highest grade completed)</li> </ol>	(Give	dent's Usual Occupation kind of work done during most of wor	king 16b	. Kind of Business/Industry	
21	vithin ne. han '	ldm	Elementary/Secondary (0-12) College (1-4or 5+	)	DO NOT use retired)			
C	iled v lygie ther t		1 Z –  17. Father's Name (First, Middle, Last)	Direct	or of Special Oly	mplcs Mo		ty
anc	ntal had of	Be	Edward Ellis Crowson			Collins	,	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: If item 21s and 24s of 28s-f show important: If item 21 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, Ite Marical Examiner must be multified at any injury or other traumatic event, Ite Marical Examiner must be multified at ance.	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailii	ng Address (Street and Number or Ru		ty or Town, State, Zip Code)	
Ma	ith ar 27 is trau		Robert E. Crawson/ Son	119 (	Crosstimber Way, 1	Frederick.	Marvland 217	02
re,	s 1 and 2 f Health item 27 other tra	1	20a. Method of Disposition	20b. Place of Dispo	sition (Name of	-	. Location - City or Town, Sta	
E	Pages nent of h ant: if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)	Memorial	natory or other place) awn Park May	14. 2004 Ro	ckville, Mary	fland.
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Arvice L censele	2	2. Name and Address of Facility is Ol	pert A. Pui	mphrey Funera	1 Home/
m	Deparenti Importanti any ir			00689 RG	ckville, Inc. 300 Rockville, Mary	Land 20850	-2805	е,
			23a. Part 1 Effective disease, or complications that caused shock of heart failure. List only one cause on each line	death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,	Approx	ximate al Between and Death
	Physician		Immediate Case (Final disease of Condition a Colon Ca	ncer			Onser	and Death
	/Medical Examiner		resulting in death)  Due to (or as a	consequence of):				
	LXammer	<u>.</u>	Sequentially list conditions.	consequence of):				
	ed Isit	nine	cause. Enter Underlying Cause (Disease or injury	consequence on.				
	xacul and al-trar	Examiner	that initiated events c.	consequence of):				
09/	cate ba exacuted physician and the burial-transit	cal E						
68760	death certificate ba exacuted e attending physician and od for use as the burial-transit	ed	4.					
Вох	death certifica attending ph d for use as t	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome o 1 □ Live birth 2		⊒Ectopic pregnancy		23d. Date of delivery	
	deat	sicia	in the past 12 months?  1 Yes 2 No  4 Pregnant at ti		Other (specify)		Month Day	Year
P.0	that the de led by the a detached f	Physician/M	9 Unknown			one Didashar	and the second	a of doubb?
	og ge	þ	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause given in Part I.	1 ☐ Yes	co use contribute to the cause  2 🖾 No 3 🗆 Probably	
ord	w raquires been sign should be	ted	Prostate Cancer					
Records,	> 0 0	Completed				24a. Was an autopsy performed	24b. Were autopsy find prior to completion death?	lings available n of cause of
E	: The cate h					1 ☐ Yes 2 🔯		)
Vital	ding Physician: The fav n. After this certificate has funeral director, page 2	Be	25. Was case referred to medical examiner?  Hospital:		Othon	th (Check only one)	0.500	
of	Phys rat di	: To	27. Manner of Death 28a. Date of Injury	t 2 ER/Outpaties	IL SELDOA 4E INUISING H	28d. Describe how in	e 6 □Other (Specify)  njury occurred	
on	ding th. Afte fune	tlor	1 X Natural 5 ☐ Pending (Month, Ďaý 2 ☐ Accident investigation	Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	Attending r death. actor: Afte by the fune	ifica	3 Suicide 6 Could not be 28e. Place of Injur	ry - At home, farm, st	reet, factory, office	28f. Location (Street City or Town, S.	t and Number or Rural Route	Number,
Ö	al or s afte il Dira	Certification;	4 ☐ Homicide determined building, etc.	(Specify)		Chy or Town, S.	1210)	
	pspits hours unera ly fille		29a. Certifier tx Certifying Physician: To the best of (Check only 2 Medicel Examiner: On the basis of	f my knowledge, deat	h occurred at the time, date and place	, and due to the cause	e(s) and manner as stated.	use(s)
	the H in 24 the F iplete	ledical	one) and manner stat					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Σ	29b. Signature and title of certifier  (I) - Knhva M		29c. License number D21336		Date signed (Month, Day, Ye) May 11, 2004	ral)
	J'		7 0000 -	d 0			1ay 11, 2004	
	10		30. Name and address of person who completed cause of de			1 01100		
	C+	ate	Albin Kuhn, M.D. 8028 Ritch: 31. Date filed (Month, Day, Year) 32. Registral		, rasadena, Mary	Land ZIIZZ		
8	Regist		31. Date filed (Month, Day, Year) MAY 1 2 2004 32. Registrar		Loans 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** COLF EMILY 12:10 PM 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALT More
If Under 1 Year | If Under 24 Hr JATI92ON Baltimore DOTTHWEST Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 Z F Yrs. 215.70-605 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County or 28e-f show 27 is marked other then "natural", or Items 23e or 28e-f shov treumetic event, the Medical Examinar must be a withing at 1 ☐ Yes 2 No Director Woodlawn Baltimore Manyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 u.SA Court Carterick 7428 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 Yo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mercy Medical Center 12 Radio10915T 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be in and 2 should be fi Health and Mental F tem 27 is marked ot ElMer EVA Richardson Wright P 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cole item 27 i Reginald Μ. 7428 Catterick Ct. Woallaim MD 21244

Date 20c. Location - City or Town, State other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Importent: If ite
eny injury or otl Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cometery MAY 15,04 Battimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronard A. akmyson Fineral Home 108West Nirthaw, Baltimo 2120/ unald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final GOITASIGNA PNEUMONIX **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): SCLEROSIS Examiner MULTIPLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) buria}-1 nding physician Physician/Medical the as 1 IF FEMALE eşn If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 2 No 3 Probably 4 □Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 1 Yes certificate Physicien: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 0 1 🗌 Yes 1 PInpatient 2 ER/Outpatient 3□ DOA this After this funeral d Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 X Natural 5 Pending 2 🗌 No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after 24 hours a Funerel ( Medicai 29a. Certifier Expectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the

Registrar

()

NORTHWEST 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAY 1 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL



5401

QVD

OLD COURT

29c. License number

HIRCEL

D54352

ROAD

TODOR

29d. Date signed (Month, Day, Year)

MD

2004

21133

MAY

RANDALLSTOWN

			1 - For State Registrer	State of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of L			giene Reg. No. 2014	15086
	Physicia		1. Decedent's Name (First, Middle, Last) Louis James Cit	ro				2. Date of Dea May 7		3. Time of Death 9:08 P M
	/Medic Examin		4a. Fecility Name (If not institution, give s 4321 Soth Avenue	treet and number)		4b. City, Town, or Baltimore		h	4c. County of Death Baltimore	
	Funeral Director		210 01 0200	7. Ag M 2□F 82	e (In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month Day	v. Year) Count	ace (State or Foreign try) none,Maryland
	Maryland f show	ō	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimore		10c. City, Town or L				10	0d. Inside City Limits 1 ☐ Yes 2 🙀 No
	with the 1 3a or 28a-	Direc	10e. Street and Number 4321 Soth Avenue			10f. Zip Code 21236			10g. Citizen of What Count	try?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene item 27 ia marked other than "natural", or items 23a or 28a-f show other traumatic event, tha Medical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Nowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	Black, White, e	
Maryland 21215-0036	within 72 hou ene. than "natura ha Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired	luring most of wo )	rking	16b. Kind of Business/Ind	
land 2	12 should be filed within n and Mental Hygiene. r la marked other than raumatic event, tha Ma	To Be Co	17. Father's Name (First, Middle, Last)  Joseph Citro						Maiden Sumame)	'
	Health and Nealth and Nealth and Nealth and Nealth and New 27 is mail other traums		19a. Informant's Name/Relationship (Ty, Allison Citro (Daughte		9805	Magledt Road		ore,Marylar		
Baltimore,	Page nent o int: if	3	20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		Parkwood C	emetery May	11 2004		20c. Location - City or To Baltimore ,Maryli	
Ball	permit. Departi Imports any infu		21. Signature of Funeral Service Licens	o Chara	rk: 17	assann Funer 401 Belair F	Road Balti	more,Maryla	and 21236	Approximate
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	META	a consequence of):				casur Pron	Interval Between Onset and Death
90,	be executed sician and burial-transit	I Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s	a consequence of):					
.O. Box 68760	ath certificate ittending phy or use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	d	2 Fetal death 3	□Ectopic pregnancy			23d. Date of delive Month	ry Day Year
0	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions con	ntributing to death b	out not resulting in the	underlying cause give	en in Part I.		obacco use contribute to the	e cause of death?
Records,	sicien: The law requi certificate has been irector, page 2 should	Completed								osy findings available inpletion of cause of
/ital	ertifica ector,	Be	25. Was case referred to medical examiner?			0"		ath (Check only o		····
on of V	ing Phy After this uneral d	은	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	lospital: 1 Inpati 28a. Date of Inju (Month, Da		of 28c. Injun World	y at		dence 6 Other (Specify now injury occurred	9
Division	al or Attending s after death. al Director: After ad in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Number or Rura vn, State)	Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (	(Check only 2 Medicel Exemi		of examination and/or i	nvestigation, in my o	pinion, death occ	urred at the time,	cause(s) and manner as stadate and place, and due to	the cause(s)
	with Tot	Σ	29b. Signature and title of certifier	zeno	40	29c. Licens			29d. Date signed (Month, I	Day, Year) 2004
7	13x,		30. Name and address of person who co	ompleted cause of		p, Print) 76	72 c	Belair MD 2	Rd.	
b	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 2 2004		rar's Signature	Arm se	, R			

			For State Registrar	State of Ma	aryland /	Departm <i>Certific</i>			and M	ental Hy	gien Reg. N	400	4	150	87
	Physici	an	1. Decedent's Name (First, Middle,							2. Date of De Month	D	ay Yea		3. Time of De	
	/Medic		Richard O. Cati							May 10		004 Yea		3:45 I	Р м
	Examin	er.	4a. Facility Name (If not institution,				ity, Town, or		of Death			c. County of D			
			Montgomery Hosp: 5. Social Security Number		use (In yrs. last bi		ckvil.		24 Hrs.	8 Date of Bi		ontgom		on (State of F	Foreign
	Funeral Director		215-38-6498	1⊠M 2□F	62	Yrs. Mon		Hours	Min.	8. Date of Bing (Month, Date Sept. 8.	1 9	41		e (State or F yland	Orangiri
			Usual Residence of Decedent							эсре. О,	, 10	7.4	1141	yrand	
	rylan thow		10a. State 10b. County		10c. City, Tov	wn or Location							10d	I. Inside City	
	Be-f s	cto	Maryland Montgor	nery	Rockvi									1 <b>∑</b> Yes 2	No
	th with the Marylan 23a or 28e-f show	Dire	10e. Street and Number	_		10f	Zip Code	- 0			-	itizen of What			
	s 23s	erai	620 Monroe Stree	12. Was Decedent 8	Ever in LLC	12 Was D	208.		ain? /Spo	oifu Voc or N		ted Sta			
	Item	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	ło	If Yes,	specify Cuba	n, Mexican	n, Puerto I	cify Yes or No Rican, etc.)		Black, W			
336	urs af	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	Korea	1 ☐ Ye	s 2 No	Specify:				Specify: W	nite		
9-0	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or Items 23a or 28e-1 show ent, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest	Education	16a	a. Decedent's (Give kind o	Isual Occup	ation	t of workin	20	16b. I	Kind of Busine			
21	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NO	T use retired	()	COL WOTAN	<i>,</i> 9					
2	ygier ygier her th		12	_	Ma	aintena	nce D			(First, Middle		iversit	t <u>y</u>		
and	s should be filed within and Mental Hygiene. s marked other then sumatic event, the Mes	Be	17. Father's Name (First, Middle, La Owen B. Catron	151)				Ne1		Go11e		,			
2	d Me mark matic	٩	19a. Informant's Name/Relationshi	n (Type Print)	19	h Mailing Add	ess (Street					or Town, State	a Zin C	nde)	
S	s 1 and 2 should be filed within 72 hours after dea of Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items other treumatic event, the Medical Examination		Deirdre D. Marti									PA 1942		300)	
<u>6</u>	s 1 and 2 i Health Item 27 I		20a. Method of Disposition		20b. Place	of Disposition	Name of			ate		ocation - City		n, State	
ê	Pages entoi nt; if i		1 ☑ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe		Memor	Parkla Parkla i al Pa	m rk	Ms	av 14	2004	Roc	kville	M -	rulan	d
Baltimore, Maryland 21215-0036	permit. Pages of Popartment of Pimportent: If ite any injury or of once.		21. Signature of Funeral Service Li	censee	, remot	22. Nam	and Addres	s of Facilit	v Robe	ert A.	Pum	phrev F	Tune	ral Ho	ome/
m	permi Depar Impo any ir		* AKAN J	1star M	100689	KOCKV	ockvi	inc.	300 Mary]	West N Land 20	10nt 1850	Somery -2805	Ave	nue,	
			23a. Part1. En er he disease, or c s lock, or he mfail re. List or	omplications that caused nly one cause on each lin	the death. Do	not enter the	node of dyin	g, such as	cardiac o	r respiratory a	arrest,		Ir	pproximate iterval Betwe	en
	Physician	Į Ņ	Immediate use (Final disease or condition	_a_Advance	d Lung	Cancer	metas	stati	c to	the Br	cain			er 3 M	
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence	of):									
		er	Sequentially list conditions,	b	a consequence	off							-		
	nsit	nine	if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury	250 (5) (6) 45 (	a concoquence	. 01).									
Ć.	te be executed ysician and te burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or as a	a consequence	of):							1		
,760,	<u>a</u> × a	icai		d											
	Physicien: The law requires that the death certifica this certificate has been signed by the attending phr ral director, page 2 should be detached for use as th	Med	IF FEMALE:												
Вох 68	ath ce tendii	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		h 3□Ectop	c pregnancy				-	23d. Date of o	delivery Da	ay Yea	ar
	at the dea by the al	Physician/Med	1 Yes 2 No	4☐Pregnant at 9☐ Unknown	time of death	5 Othe	(specify)					WORT		29 100	
P.O.	hat th d by detacl		Part II. Other significant condition	s contributing to death bu	ut not resulting	in the underlyi	in cause nivi	en in Part I		23e. Did i	tobacco	use contribute	to the	cause of dea	ath?
ds,	uires that signed b	d by				.,,	· · · · · · · · · · · · · · · · · · ·			152	Yes 2	2 □ No 3 □	Probab	ly 4 Uni	known
Š	w requ	ete								24a. Was	an	24h Ware	autons	y findings ava	ailable
Re	The law ate has page 2	Completed								auto perfe	psy ormed?	prior t death	to comp	letion of cau	se of
To To	icien: Th certificate rector, pag	ပိ	25. Was case referred to medical				<del></del>	26 Place	of Death	1 ☐ Yes (Check only	2 <b>2</b> N	o 1□Y	es 21	□ No	
>	ysicie is cert direct	0 B	examiner? 1 □ Yes 2 <b>X</b> No	Hospital:	nt 2 ER/O	utpatient 3	DOA Othe					6 ther (S	pecify)	Hospic	. 6
0	ig Phys ter this neral di	n: T	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. Injury Work	at	2	8d. Describe	how inju	ry occurred			
	endin sath. or: Af he fur	atic	1 Natural 5 Pending 2 Accident investiga	tion	,,	М		Yes 2 1	No						
Oivision of Vital Records,	or Att	Certification:	3 Suicide 6 Could no 4 Homicide determin		iry - At home, f c. (Specify)	arm, street, fa	tory, office		2	8f. Location ( City or To	Street a wn, Stat	nd Number or 'e)	Rural A	loute Numbe	H,
۵	pitel curs af		One Cartillar 1970 antifular	Physician Table have		- 4			1						
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E:	Physicien: To the best of xaminer: On the basis of and manner sta	examination a	ge, death occur nd/or investiga	red at the tim tion, in my of	ne, date an pinion, deat	d place, a th occurre	ind due to the ad at the time,	date ar	s) and manner id place, and d	as state	e cause(s)	
	o the	Me	29b. Signature and tube of certifies	111/2			29c. License	e number			29d. Da	ate signed (Mo	nth, Da	y, Year)	
	->- o		Mille	44/1	1		04	12	18	-	E	5/40	10	4	
	1XA		30. Name and address of person w				- 1	+01				1 0		+	
_	1.,		Charles Harrison			aster M	ill R	oad, 1	Rocky	ville,	MD	20855			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 2 2004	Sentra	ar's Signature	Son	Kal								

Decoder S Name   First, Middles   Last    Sample   Samp			1	For State Registrar	State of Maryland	-	ırtment of H <i>tificate of L</i>		lental Hygien Reg. N	Z U U 14	15088
Example  Suburban Hospital  Funeral  Funeral										ay Year	3. Time of Death
Deputing the property funds of the control of the property funds o					Edward W. Cox				May 4	2004	11:35 PM <sup>M</sup>
South Blackery Number   0 See   1 Se				4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	4	c. County of Deat	h
The composition of the control of th	ı			Suburbar	Hospital						
Total Action City Limited   Control of Notice   Control of Notice City   Control of Notice Cit		Funeral							8. Date of Birth (Month, Day, Yea	r) 9. Birt	hplace (State or Foreign nuntry)
To State of Control Country of	н	Director		220-58-8147	50	Yrs.			January 29,	1954   Cor	nnecticut
Robert R. Cox    Name		pu ,	}-		10c City	Town or Lo	cation				10d. Inside City Limits
Robert R. Cox    Name		aryla shov		Tod. State	1.55. 5.147						1 ☐ Yes 2 📉 No
Robert R. Cox    Name		8a-f	octo		mery			ensington		itizen of What Co	untry?
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Robert R. Cox    Name		er de	une	11. Wallar States	Armed Forces?	13.	f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		
Robert R. Cox    Name	36	s afte	γF		If Yes, Give		1X Yes 2□ No	Specify:	to Pican	Specify:	White
Robert R. Cox    Name	Ş	hour tural	pe l			16a, Dece	dent's Usual Occupa	ation	16b.	Kind of Business	
Robert R. Cox    Name	<u>.</u>	n 72 n "na n "na	let	(Specify only highest grade	e completed)	(Give life. i	kind of work done on DO NOT use retired	during most of work !)	ing		
Robert R. Cox    Name	12	withi ene. thar	mc		College (1-4or 5+)		Of:	ficer		Secur	ity
23. Part. Enter the "disease". *** According the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  **Previous or Myocardial Infarction  **Due to (or as a consequence of):  **Due	0	filled Hygi othar ant, I							e (First, Middle, Maid	en Sumame)	
23. Part. Enter the "disease". *** According the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  **Previous or Myocardial Infarction  **Due to (or as a consequence of):  **Due	an	d be ental ced c	m	Rohe	ert R Cox				Maria <sup>-</sup>	. Rosicl	า
23. Part. Enter the "disease". *** According the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  **Previous or Myocardial Infarction  **Due to (or as a consequence of):  **Due	<u> </u>	shoul nd M	F.			19b. Mailir	ng Address (Street	and Number or Rura		A	
23. Part. Enter the "disease". *** According the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  **Previous or Myocardial Infarction  **Due to (or as a consequence of):  **Due	Š	nd 2 and 2 a		Maria T. Cox/ Moth	ner	1112	l Newbort	Mill Roa	d Kensing	on, Mar	land 20895
23a Part. Enter the "Glease"   Approximate and Death   Cheek only or elease of vesting and part   Cheek only or elease of part   Cheek only or elease of part   Cheek only or elease of part   Chee	<u>o</u>	tam tam	33	20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of				
23a Part. Enter the "Glease"   Approximate and Death   Cheek only or elease of vesting and part   Cheek only or elease of part   Cheek only or elease of part   Cheek only or elease of part   Chee	UQ	ages ant of it: If i	l i		temoval from State			!	1 2004 1	Brony No	w Vork
23. Part. Enter the "disease". *** According the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  **Previous or Myocardial Infarction  **Due to (or as a consequence of):  **Due	₫	artme ortan injur				22 22	2. Name and Addres	ss of Facility Rob	ert A. Pur	nphrey Fu	ineral Home/
23. Part. Einter the disease   Secondario from the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown or near failure. List only one cause on each line.  Who cardial Infarction  The following in death in resulting in death in resulting in death in resulting in death in resulting in death in the cause of the control of	Ba	Dep lmp any		1 Dem Di	M0033	Be	ethesda-C ethesda.	hevy Chas Marvland	e Inc. /5 20814-350	55/ Wisco	onsin Avenue
Onset and Death Mocolical Examiner    Myocardial Infarction   Due to (or as a consequence of):				23a. Part1. Enter the disease, or compl	ications that caused the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate
Comparing the sequence of th		ALC: N	o vi	Immediate Cause (Final		1 TE					Onset and Death
Sequentially ist conditions, and yellow the complete of the control of the cont							arction				
The part of the pa	F	Examiner									
State   Stat			ē	if any, leading to immediate	Due to (or as a conseque	ince of):					
State   Stat		uted d ansit	Ē	Cause ruisease or injury	•						
FERMALE:	ó	exectan and and rial-tr	EX	resulting in death) Last	Due to (or as a conseque	ence of):					
FERMALE:	9/	te be ysicia ne bu	cal		d						
State   Stat	•	tifica ng ph as th		15.55141.5							
State   Stat	ŏ	h cer endir use	N/UR	23b. Was decedent pregnant			∃Ectopic pregnancy	,		]	•
1   yes 2   No 3   Probably 4   Unknown of the support of the su	<u> </u>	0 0	sick	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea		Other (specify)			Worth	oay
1   yes 2   No 3   Probably 4   Unknown of the support of the su	Ö.	at the by the	hy						OG- Didashara		- the sauce of dooth?
24a. Was an autopsy performed		as this		Part II. Other significant conditions co.	ntributing to death but not resul	ting in the u	inderlying cause giv	en in Part I.			
24a. Was an autopsy performed	ord	en si				-			1 ☐ Yes	2MN0 3UF	
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death  1 Natural of Death of Death (Month, Day Year)  28. Date of Injury at Work?  1 Natural of Death	000	as b	ple						autopsy	prior to	utopsy findings available completion of cause of
26. Place of Death (Check only one)  27. Was case referred to medical examiner?  28. Do Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28. Do Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28. Do Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28. Do Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28. Date of Injury at North 1   Natural 1   Natural 2   North 1   Natural 2   North 1   Natural 2   North 1   Natural 3   North 1   Natural		rhe te h age	E O						performed' 1 ☐ Yes 2 🛣	? death? No 1 ☐ Yes	s 2□ No
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 28b. Time of Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred 28d. Descri	ita	ian: rtifica	a					26. Place of Deat	th (Check only one)		
1   Natural   2   Accident   3   Suicide   4   Homicide   4   Ho	f <	nysic nis ce direc			Hospital: 1 X Inpatient 2 ☐ E	R/Outpatie	nt 3 DOA	er: 4 ☐ Nursing Ho	ome 5 Residence	6 □Other (Spe	ecify)
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and defect cause of person who completed cause of death (Item 23a) (Type, Print)  M. Means—Markwell, M. D. 8600 Old Georgetown Road Bethesda, Maryland 20814  31. Date filled (Month, Day, Year)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  31. Date filled (Month, Day, Year)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filled (Month, Day, Year)  29c. Registrar's Signature			ü				of 28c. Injur Wor	y at k?	28d. Describe how in	jury occurred	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and defect cause of person who completed cause of death (Item 23a) (Type, Print)  M. Means—Markwell, M. D. 8600 Old Georgetown Road Bethesda, Maryland 20814  31. Date filled (Month, Day, Year)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  31. Date filled (Month, Day, Year)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filled (Month, Day, Year)  29c. Registrar's Signature	<u>Ö</u>	ath. ath. or: Af	atlo	2 Accident investigation			M 1 🗀	Yes 2 □ No			
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and defect cause of person who completed cause of death (Item 23a) (Type, Print)  M. Means—Markwell, M. D. 8600 Old Georgetown Road Bethesda, Maryland 20814  31. Date filled (Month, Day, Year)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  31. Date filled (Month, Day, Year)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filled (Month, Day, Year)  29c. Registrar's Signature	ĭ	r Atta	ţį	dataminad			reet, factory, office				ural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. Means-Markwell, M.D. 8600 Old Georgetown Road Bethesda, Maryland 20814  State 31. Date filed (Month, Day, Year)  22. Registrar's Signature		ital o irs aft ral Di led in						-			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. Means-Markwell, M.D. 8600 Old Georgetown Road Bethesda, Maryland 20814  State 31. Date filed (Month, Day, Year)  22. Registrar's Signature		d hou thou thou thou thou thou thou thou	cal	(Check only 2 Medical Exam	inar: On the basis of examinati	rledge, dear on and/or in	th occurred at the til rvestigation, in my o	me, date and place, pinion, death occur	, and due to the cause rred at the time, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. Means-Markwell, M.D. 8600 Old Georgetown Road Bethesda, Maryland 20814  State 31. Date filed (Month, Day, Year)  22. Registrar's Signature		tha hin 2, tha litha lit	led		and manner stated.		29c Licens	se number	29d.	Date signed (Mon	th, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. Means-Markwell, M.D. 8600 Old Georgetown Road Bethesda, Maryland 20814  State 31. Date filed (Month, Day, Year) 22. Registrar's Signature		To To	-		200014	000					
M. Means-Markwell, M.D. 8600 Old Georgetown Road Bethesda, Maryland 20814  State 31. Date filed (Month, Day, Year) 2. Registrar's Signature	•	0,						54722		May 5, 2	2004
State 31. Date filed (Month, Day, Year) 22. Registrat's Signature		/						and Ratha	acda Marri	land 200	1 4
		C+	ate		22. Registrar's Signati	Iroll		oau Decile	.oua, Mary.	ranu 200.	<u> Т</u>
					Denva /	0	sports				

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** May 9, 2004 Edward Francis Clagett 4:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Gaithersburg 18405 Gardenia Way If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 X M 2 □ F 263-80-8841 June 26, 1947 Maryland Director 56 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "netural", or Items 23a or 28a-f ehow the Medical Examinat must be notified at 1 Yes 2 No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20879 United States death y Funeral <u>18405 Gardenia Way</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or iten any injury or other traumatic event, its Madical Examinat 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Automotive 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis Gilbert Clagett Ita Anne Willard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catharine H. Clagett/Wife 18405 Gardenia Way, Gaithersburg, Maryland 20879 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition May 13. cometery, crematory or other place)
Potomac United
Methodist Church Cemetery 2004 1 Burial 2 □ Cremation 3 □ Removal from State Potomac, Maryland \*4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20852 21. Signature of Funeral Service Licensee M01346 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infarction /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. First lindarying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant at time of death P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ should be 1 ☐ Yes 2 ☒ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus Type II page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2X No Sleep Apnea Vital or Attending Physicien: 25. Was case referred to medical examiner? funeral director 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 1 X Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Division of 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Japital L. 4 hours after dec. real Director: After hy the fy 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Funeral Directory filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 5, certifier D35370 May 10, 2004 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Jan Bachowski, 11125 Rockville Pike, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 Registrar 2 2004

			State of Maryland / Department of Health and Mental Hygiene
	Physicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 3. Time of Death
	/Medic		Remaner Cole May 7 2004 8/37 AM
}	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		#:	Harbor Hospital Center Saltimore  5 Social Security Number 6. See 7. Age (In vrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth 9. Birtholace (State or Foreign)
г	Funeral		1 □ M 2 N F   Months Days Hours Min. (Month, Day, Year) Country)
-	Director		220-22-5324 86 12/15/1917 North Carolina Usual Residence of Decedent
	/land		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Man Frsh Tiel	to	Maryland Baltimore 1 Yes 2 No
	r 28e	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	38 o	O IE	3034 Southland Avenue 21225 U.S.A.
	deati ms 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
9	or Ite	Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No
8	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Marifeal Exama and marities at	i by	3 XWidowed 4 □ Divorced If Yes, Give The Year or Dates:  1 □ Yes 2 No Specify: Specify: Black
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working Iffe. Do NOT use retired)  16b. Kind of Business/Industry
2	ithin en.	ıμ	Flamentary/Secondary (0-12)   College (1-4or 5+)
2	filed w Hygier other th		5
<u>n</u>	be fit d otl	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surmame)
<u>y</u> a	should ind Men s marke umetic	To.	Ben Ramsey Julian Bass
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene if the firm 27 is marked other then "neturel", or Items 23e or 28e-f show item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Madical Event and instituted at		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209  Robert R. Coles /Son  5806 Western Run Drive Apt. B. Baltimore, Maryland
	l and lealth om 27		
0	Pages nent of Hunt: If ite		1 Derivation 3 Removal from State cemetery, crematory or other place)
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other ODGS.		
39	permit. Departm Importe any inju		21. Similare of Funeral Service Licensee 22. Name and Address of Facility The Derrick C. Jones F/H, P.A.
-	70 5 8 0		4611 Park Hgts. Ave., Baltimore, Maryland 21215
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Approximate Interval Between Onset and Death
И	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Myseardial Infarction 2 hours
f	/Medical Examiner		Due to (or as a consequence of):
i.		<b>3-</b>	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):
	ed sit	ine	cause. Enter Underlying
	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  c. Due to (or as a consequence of):
760,	be executed ician and burial-transit	cal E	Non-insulin dependent diabetes mellitus 40 year
687	ys ys		d. Tovi his a till defen acti and and all mentions to year.
×	death certifica e attending ph id for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent prepnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
Box	atter for L	ciar	in the past 12 months?    I   Live birth   2   Fettal death   3   Ectopic pregnancy   Month   Day   Year   Month   Month   Day   Year   Month   Month   Day   Year   Month   Mo
o.	that the deatled by the atte	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown
σ.	requires that the	y P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
rds	quires n sigr	Q p	NON-INSULIN diabetes mellitus 1 Yes 20 No 3 Probably 4 Unknown
000	w require been sign	lete	His force of a straintesting / bleed 24a. Was an 24b. Were autopsy findings available
Vital Records,	The law ate has b page 2 s	шс	autopsy performed? prior to completion of cause of death?
ta		e C	Type 20No 1 yes 20No 1 yes 20No 25. W. c se referred to medical 26. Place of Death (Check only one)
		o B	examiner?  1 X yes 2 No  Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)
of	g Phy er this eral di	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
Division	Attending ir death. ector: After by the fune	atio	1 Matural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No
<u>×</u>	Attendi	ifici	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ö	s afte	Certification:	Sulfidancy, atc. (Specify)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier (Check only   Check only   Ch
	the H hin 24 the F nplete	edical	one) and manner stated.
	To the within 2 To the complet	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
			Zerold Upollon M.D. D3/8/4 May 7, 2004
	F 44		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harbor Hospital  Gerald Anollon M.D. 3001 South Hanbuer Street, Baltimore
	4		
	Sta	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature  MAY 1 2 2004
	Registr	ar	min 2 4 LUU4 file of fraction

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:45 P M KOSE CHESTER 03 10 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Riverview Nursing Home Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Pebruary Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🕅 F 93 216-01-4792 Director VA. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ent: If item 27 is marked other then "netural", or Items 23e or 28e-f show ury or other theumatic event, I'm Medical Espating must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2X No Baltimore Edgemere MD. Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 USA 6604 North Point Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give\* Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Tompanko Thomas Podruchny 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is eny injury or other treu once. 2919 Wells Avenue, Edgemere, MD. 21219 Benjamin Chester son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State Holy Trinity Russian Orth. May 14,2004 Elkridge, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Connelly Funeral HOme Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21. Signature of Funeral Service Licensee 21222 23a. Part1. Enter the disease or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical **Examiner** y per tenero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of) Examiner and I-transit The law requires that the death certificate be executed 1 yearcho! physician ar s the burial-tr P.O. Box 68760. uhemi Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2. No 3 Probably 4 □Unknown Completed 5 leading 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Voursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA 2 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: To the Hospitel or Attending 1. Natural 5 Pending investigation 1 🗌 Yes within 24 hours after upan... To the Funerel Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Tecritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and tyle of certifier SEBASTIAN JOHN O 0055171 10 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
3023 Eastern Arenne, Both more MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 2 2004 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 () () [ 15092 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 **Physician** MAY 9, COONIN MANUEL 6:00 P M /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12325 FALLS ROAD COCKEYSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. June 12, 1918) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 ☐ F 85 Director 216-05-4947 Yrs. MD Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director COCKEYSVILLE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 12325 FALLS ROAD 21030 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I □ Yes 2 X No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE ģ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** MARYLAND JOCKEY CLUB permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event ang. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KUNIN ABE MOLLIE **GELLER** ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BLANCHE COONIN / WIFE 7524 SEVEN MILE LANE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5 Other (Specify) ANSHE EMUNAH (AITZ CHAIM) 5/10/2004 BALTIMORE, MD uneral - rvice Li 21. Signs 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in each line. 23a. Part1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ESTIVE /Medical Due to (or as a consequence of) Examiner STERIOSCIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 ₩0 ျှ 3 DOA 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) k004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RVBN MO. Crush, 160 21135 82. Hegistrar's Signature 2004 State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month May 8, 2004 6:20P Bierwes Deranger /Medical Margarete 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Meridian Center Baltimore Co. Dundalk 8. Date of Birth (Month, Day, Year) March 30, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 XF Days Hours 84 Director 464-48-7338 Germany Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits \*how r 28a-f show 1 Yes 2 No Directo Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If itam 27 is marked other than "natural", or Itams 23a or: ury or other traumatic event, the Madical Examinate must be r 21222 8400 Kavanagh Road United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11 Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 2 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Antoinette Jung Hubertus Bierwes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6459 Summer Cloud Way Columbia, Maryland 21045 Andrew Deranger (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State ortant: \* 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 5/11/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Parme and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** FMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duly to (or as a consuguence of) Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 D⊌nknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1□ Yes 2**2** No 1 Yes 2 NO of Vital or Attanding Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Fursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner eath 28d. Describe how injury occurred After 5 Pending investigation 1 L atural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide To the Hospital within 24 hours a To the Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) th (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature Year) State Registrar 2 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9 Alan Dickey Mav 2004 3:35 A /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 6. Sex If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 1 M 2 □ F 286-14-8209 89 Director 13, March 1915 Ohio Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "netural", or itams 23a or 28a-f shoutraumatic event, the Medical Examination must be notified at |Maryland |Montgomery 1 Yes 2 No Garrett Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10715 Weymouth Street 20896 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Armed Forces.

1 Sizes 2 No
If Yes, Give World
Year or Dates: War I 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify Specify: þ 3₺Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
COST 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Elementary/Secondary (0-12) College (1-4or 5+) Government Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Malcolm Dickey Grace Thome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert B. Dickey/ Son If item 27 P.O. Box 64, Garrett Park, Maryland 20896 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 15, permit. Page Department o Important: If eny injury or gnce. injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Grandview Cemetery Chillicothe, Ohio 2004 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Betnesda, Maryland 20814-3501 21. Signature of Funeral Service License M00689 23a. Part I that the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book to ear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Cancer of the Bladder years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, flany leading to misocare cause. Enter Underlying Cause (Disease or injury Due to (or as a consuguence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 ☐ Yes 2 😾 No To the Hospitet or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 🔀 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Bignature D38457 May 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nakul Goyal, M.D. 3801 International Drive, #211, Silver Spring, MD 20906-1550 31. Date filed (Month, Day, Year) MAY 1 2 2004 32. Registrar's Signature State pails Registrar

	1-	For State Registrar	Please			l / Depa		lealth and	Ali Copies Mental Hyg	_	ible.	15095
Physician /Medical	1. De		e (First, Middle, La	st)	Dimick				2. Date of Dea Month May 9	ath Day	Year	3. Time of Death 6:04 P M
Examiner	4a. F		f not institution, givenue	re street and num			4b. City, Town, o	or Location of Dea		4c. Count	y ol Death	
Funeral Director	5. Sc	ocial Security N	umber 6.	Sex 7	7. Age (In yrs. la		If Under 1 Year Months Days					place (State or Foreign
D	10a.	al Residence of State	10b. County		10c. City,	Town or Lo						0d. Inside City Limits
fire death with the Mauritems 23a or 28a-1 si	10e.	MD. Street and Nur	N/A		Ват	timor	10f. Zip Code			10g. Citizen of	What Coun	1 XYes 2 □ No
eath wi	37	28 Fait	Avenue	12 Was Dece	dent Ever in U.S	13.1	21224	dispanic Origin? (5	Specify Yes or No-	USA 14. Ba	ce - Americ	an Indian
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show may jointy or other traumatic event, the Modeal Examinational Be notified at once.  To Be Completed by Finneral Director	3		ied 2 Married 4 Divorced	Armed Ford  1  Yes  If Yes, Give  Year or Da	ces? 2XINo	'	Yes, specify Cub	Specify:	to Rican, etc.)	Bla	ock, White, by: Whit	etc.
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or may injury or other traumatic event, the Middle Examples.	El	(Spec	15. Decedent's E ify only highest gr indary (0-12)	ducation ade completed) College (1-	4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retire	during most of wa	rking	16b. Kind of E	Business/Inc	iustry
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Mar nd 2 sho alth and 27 Is m			ame/Relationship Dimick	(Турө, Print) SOY	ı		-		ura/Route Numbe altimore,			Code)
TOTE,			position Cremation 3 [ 5 Other (Speci		tate cer	metery, cren	sition (Name of natory or other pla Cemeter		Date 13, 2004	20c. Location		wn, State
Baltir permit. F Departme Importar any injur ance.			neral Service Lice	<del></del>	Con	00 C	Name and Addre	ss of Facility Funeral H	Home Of D	oundalk	.P.A.	1222
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Cords, P. w requires that the been signed by should be deta	rant.	II. Other signif	icant conditions	contributing to dea	ath but not result	ing in the ur	iderlying cause gru	ren in Part I.		bacco use con es 2□No		e cause of death?
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of Vital Rehysicien: The I his certificate ha Ldirector, page	25. \	Was case refer examiner? I □ Yes 2 ☑		Hospital:	patient 2□E	R/Outpatien	3 DOA O#		ath (Check only or fome 5 ) Resid			
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Division of tell or Attending P is after death.  al Director: After ted in by the tuners certification:	3	3 🗍 Suicide 4 🔲 Homicide	6 Could not be determined	289. Place 0	of Injury - At hom g, etc. <i>(Specify)</i>	ne, larm, stro	eet, factory, office		28f. Location (S City or Town	treet and Numi n, State)	ber or Rural	Route Number,
Divisic To the Hospitel or Attent within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certificat		Certifier (Check only one)	1 Certifying P 2 Medical Exa	hysician: To the t miner: On the bas and manne	sis of examinatio	n and/or inv	estigation, in my o	pinion, death occu	a, and due to the curred at the time, d	ate and place,	and due to	the cause(s)
To ti withii To ti comp	29b.	Signature and	title of certifier	12	1		29c. Licens	e number	2	9d. Date signe	d (Month, E	ay, Year)
6	30. N	Vame and addr	ess of person who	mpleted cause	of death (Item 2	23a) (Type, I	Print)	) le 5 le	maryla	nay 1	0,2	coy
State	31. [	3 ) Date filed (Mon		32. Re	Aven	TO.	1561720	WID TH	mary 16	-d	21	213
Registrar			1 2 2004		wa /	5,	partis	•	•			

			1- State of Maryland / State of Maryland / Registrar AMEND TIEM # 7 PER FH C831 5/12/0	Depa 4 Olde	artment of H	lealth ar Death	nd Mental Hy	ygiene 2 {	)04	15096	
	Physici /Medic		Decedent's Name (First, Middle, Last)     ZELMAN		DUKSTANSK	(IY	2. Date of D Month MAY	9 <sup>Day</sup>	2004	3. Time of Death 5:55 P M	
	Examin	er	4a. Facility Name (If not institution, give street and number)  JEWISH CONVALESCENT CENTER		4b. City, Town, o	RE		4c. Count	RE		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 10. Age (In yr	Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of 8 (Month, D	irth Pay, Year) 6,1919	9. Birthplace (State or Foreign Country) 1919 UKRAINE		
	ryland how		Usuel Residence of Decedent  10a. State 10b. County 10c. City, To							10d. Inside City Limits	
	the Ma	recto	MD BALTIMORE I	PIKE	SVILLE 10f. Zip Code			10g. Citizen of	What Cou	1 ☐ Yes 2 🔀 No	
	23a or	ral Di	16 OLD COURT ROAD #520			21208		UKRAINE			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show eny injury or other treumatic event, the Medical Evaruher must be inclifted at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 N No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origir an, Mexican, I Specify:	n? (Specify Yes or N Puerto Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc.  Specify: WHITE		
21215-0036		mpleted	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired NEER	during most o	of working	16b. Kind of E	ndustry		
land 2	should be filed with the standard Hygie marked other lamatic event, II	To Be Co	17. Father's Name (First, Middle, Last)  MOSES  DUKSTA			18. Mother's	s Name (First, Middl	1	me)	RHALTER	
Maryland	d 2 shouth and N th and N the mar				_		or Rural Route Numi 520 - PIK				
	pes 1 and of Health				osition (Name of matory or other place		Date	20c. Location	-		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		'4 □Dogation 5 □Other (Specify)  21. Sign two of inneral Service Lice 10.10	-	HEBREW C 2. Name and Addre		5/11/2004 SOL LEVIN			OWN, MD	
ä	Depa Impo eny ii		23a. Part 1. Enter the disease, or complications that caused the death. Do	8	900 REIST	ERSTO	NN ROAD -	PIKESVI		MD 21208	
	Physician /Medical		shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)	611	M GRS	DISE	SASE	arrest,		Approximate Interval Between Onset and Death	
	Examiner and I-transit	ų.								*	
Ī		Examiner	Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence co.								
8760,	cate be executed physician and the burial-transit		d								
O. Box 6	at the death certifica by the attending ph tached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetel dea   4   Pregnant at time of death   9   Unknown   Unknown   1   Exercise   1   Exerc		□Ectopic pregnancy □ Other (specify)	,			ate of delivionth	very Day Year	
۵.	an the	by	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause giv	en in Part I.		tobacco use co		the cause of death?	
I Records,	The ate ha	Completed					24a. Waa auto pen 1 □ Yes		Were autoprior to codeath?	opsy findings available impletion of cause of	
Vital	Physicien: The this certificate har director, page	o Be	25. Was case referred to medical examiner?   Hospital: 1   Inpatient 2   ER/C	Outnatie	nt 3 DOA Oth	or /	Legath (Check only ing Home 5 ☐ Res		her (Speci	ful	
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Division	in Jife	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	reet, factory, office			(Street and Num. own, State)	ber or Run	al Route Number,	
	e Hospital 24 hours a e Funerel ( letely filled	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowled and manner stated.	ge, deat	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	cause(s) and m , date and place,	anner as s and due t	stated. the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and vitle of certifier	AA	29c. Licens	e number	22	29d. Date signs	ed (Month,	Day, Year)	
•	\		30. Name and address of person who completed cause of death (Item 23a	) (Type,	Print) P	1/2	1	1-411	10	4004	
	Sta	te_	31/Date fled (Month, Day, Year) 32. Registrar's Signature	67	10 K	45%	the 1	(JUT)	MI)	2145	
	Registr		1 1 2 2004 Server &	1	parks		-				

			1 - For Amend Item 18 Registrar		351 <del>/(95</del> 713	ndul Repa Ce	artment rtificate	of He	ealth a Death	and M	ental H	ygiene, Reg. No.	2001	15	097
	Physici /Medi		1. Decedent's Name (First, Middle, Georgia	Last)		Davi	s				2. Date of D Month 5-1-2	Day	Year	3. Time o	
	Examir		4a. Facility Name (If not institution, 2318 Druid Par	k Drive				lti	nore				4c. County of Death		-
	Funeral Director		5. Social Security Number  217-34-9501  Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Months	Year Days	If Under : Hours	Min.	8. Date of B (Month, D	irth la <i>y, Year)</i> 4 38	9. Bi	rthplace (State country) VA	or Foreign
	Maryland f show fied at	tor	10a. State 10b. County	1		City, Town or Lo								10d. Inside C	City Limits
	with the 3e or 28s	I Director	10e. Street and Number 2318 Druid Par				10f. Zip 0	ode 121					zen of What Country?		
9003	mit. Pages 1 and 2 should be file partment of Health and Mental Hy portant: if itam 27 is marked oth y injury or other traumatic evant 28.	by Funer	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 【↑↑  Vorced	12. Was Dec Armed F ad 1 Tyes If Yes, G Year or [	edent Ever in orces?	'		nt of His y Cuban	panic Orig , Mexican	gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	0- 14	Black, Whi	erican Indian,	
21215-0036		Completed	15. Decedents (Specify only highest Elementary/Secondary (0-12) 12th grade	grade completed,	1-4or 5+)	(Give	lent's Usual kind of work DO NOT use	done di	ion Iring most	of workin	og -		of Business	ŕ	
Maryland 2		Be	17. Father's Name (First, Middle, L Roosevelt Pett	igrew					Bert	h Je	(Eirst, Middle Jenkins nkin	, Maiden S	lumame)		
			19a. Informant's Name/Relationshi  Nelson Pettic  20a. Method of Disposition	rew-So	20b.		B Dru	id ]	Park	Dri		Balti	more ation - City or	Md 2	1215
Baltimore,			1 Burial **Cremation : 4 Donation 5 Other (Society) 21. Signature of Funeral Service Li	ecify)		etro Cr	*	ory	Inc			Balt imore	imore, Md.	Md 21215	
90,	physician and physician and physician and physician transit it is burial-transit.	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, in any, leading to immediate to use to (or as a consequence of):									rrest,	Ave.	Approximatinterval Bet onset and Survey Surv	ween Death	
P.O. Box 68760	The law requires that the death certificate be the has been signed by the attending physic age 2 should be detached for use as the bear th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregr 9□Unkn	oirth 2 Fe nant at time of own	tal death 3 death 5	Ectopic preg Other (spec	fy)				230	d. Date of del Month		/ear
Records, F	w requires that been signed should be de	by	Part II, Other significant condition	s contributing to d	eath but not re	sulting in the un	derlying cau:	se given	in Part I.			obacco use Yes 2□t		the cause of do	eath? Inknown
		e Completed	Of Was see stand to the day								1 Yes	osy rmed? 2 No	24b. Were au prior to death? 1 \(\sum \) Yes	topsy findings a completion of ca	available ause of
ion of Vital	sir di	ToB	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigal	28a. Date (Mon.		ER/Outpatient 28b. Time of Injury		Other: Injury a Work?	4 □ Nurs	sing Home	Check only of 5 Resided. Describe I	dence 6	Other (Spec	city)	
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	tha Hospi in 24 hou tha Funer pletely fill	edical	one)	Physician: To the aminer: On the band man	best of my kn asis of examin ner stated.	owledge, death ation and/or inve	occurred at t	he time, my opin	date and ion, death	place, an occurred	d due to the at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)	
•	To To Coom	Σ	29b. Signature and title of certifier	ono	4,	MD	D	cense n	umber	4			igned (Month	, Day, Year)	
	ð		30. Name and address of person when Cho Manny, MD.	o completed caus	e of death (Ite	m 23a) (Type, F	rint) + ac	4,	Cat	onsi	ر ساار	MI	212	2-8	
	Star Registra		31. Date filed (Month, Day, Year) AAY 1 2 200	4 52. R	egistrar's Sign	ature	park								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** WAVERLY DRUMMOND 4 26 P.M. NAMI 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner HARFORD GARDENS NURSING HOME BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) JULY 15,1936 1 ☐ M 2 ☐ F 231 46 0277 67 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a. State or 289-f ehow the Medical Examiner must be notified at 1 Yes 2 No MD N/A Funeral Director BALTIMORE 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 4700 HARFORD ROAD 21214 U.S.A Items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: δ 3 Widowed 4 Divorced ear or Dates BLACK "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flamentary/Secondary (0-12) than College (1-4or 5+) LABORER CONSTRUCTION other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MATTHEW DRUMMOND MACIE BUTTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ORIS DRUMMOND 4920 HOGANS LAKE PL ANNANDALE, VA. 22003 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3X Removal from State 1 Burial 2 Cremation 4 □ Donation 5 □ Other (Specify) GOOD HOPE CHURCH CFM. MAY 15, 2004 BLACKRIDGE VA 21. Sona ure of Funeral Service Licensee CALVIN BORS FUNERAL HOME 1412 E. PRESTON ST BALTO, MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mknown Priysician · S · 6 · U · D /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause in the cause of tribury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part #. Other significant conditions contributing to death but not resulting in the underlying cause given in Part #. þ Division of Vital Records, 43 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an autopsy performed) 20 No 1 ☐ Yes or Attending Physicien: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 ER/Outpatient Medical Certification: To Yes 2 No 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number MA 0018230 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHIDHAPAN, GOOD SAMARITAN HOSPITAL, MD21239 KALATHIL 31. Date filed (Month, Day, Year) MAY 1 2 2004 32. Registrar's Signature State Registrar

		Please	Type or Print						
		1 State	State of Ma	-	epariment o Certificate d			2111	4 15000
¥1.,		Registrar  1. Decedent's Name (First, Middle, La:	n#l		verillicate (	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
Physic /Medi		YOLANDA	CLAIRE	ENG	LAND		Month May 8	Day Year	
Exami	ner	4a. Facility Name (If not institution, giv				m, or Location of De	ath	4c. County of Dea	
- Ala.	34,	13410 Arbor [ 5. Social Security Number 6. S		(In yrs. last birtho		erstown ear   fUnder24	rs P Date of Birt	Washi	
Funeral Director			□ M 2 1 7. Age	77 Yr	Months Da	ays Hours M			rthplace (State or Foreign ountry) Vew York
land ow	İ	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
Mary Ff 8th	ţ	Maryland Wash:	ington	Нас	gerstowr	1			1 ☐ Yes 2 🂢 No
th the	Director	10e. Street and Number			10f. Zip Cod			10g. Citizen of What C	ountry?
ith wil	a	13410 Arbor Dr	·ive		21	742		U.S.A.	
r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent If Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race · Am Black, Whi	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 77 is marked other than "neturel", or Items 23e or 28e-f show treumatic event, Ita Madical Erschier menter notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 □ Yes 2 💢				White
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d be antal ced o	To Be	George C.		Ldman		Eth		Jall	er
Marylan 42 should be th and Menta 7 is marked treumatic ev	-	19a, Informant's Name/Relationship (			lailing Address (Sti			r, City or Town, State,	
		Andy Weiner	Son					netonka,	
2		20a. Method of Disposition		20b. Place of D	isposition (Name o	f	Date	20c. Location - City or	
Pages Pages nent of ant: If it		Y Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	(Hemoval from State	1	shurun Ce	1	5-11-04	Rdina, Min	nesota
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	IS00		22. Name and Ad	dress of Facility	- Eupopol	Homo Too	
<b>n</b> 88888		K. hoel B	rady		40 East	Antietam	Street, b	Home, Inc. lagerstown,	Md. 21740
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as a	consequence of):	/c1	y re	ac or respiratory and	est,	Approximate Interval Between Onset and Death
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IS, P.O. Bries that the deat signed by the attribe detached for	ysicla	in the past 12 months? 1 ☐ Yes 2 ☐ 10 9 ☐ Unknown	4☐Pregnant at tir 9☐Unknown		5 Other (specify			Month	Day Year
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VItal Records, iician: The law requires t certificate has been signe rector, page 2 should be o							1 □ Y	es 2⊟No 3⊟Pr	robably 4 Unknown
ecor law requas been 2 should	Completed						24a. Was a		utopsy findings available
The The gas	mo						autops perfori	med?death?	completion of cause of
VITAL I	Be	25. Was case referred to medical examiner?				26. Place of D	eath (Check only or		
of Vital Physician: r this certifica	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpa	IIIII 3 DOA	The second second second second	Home 5 Reside	ence 6 Other (Spe	cify)
	i.i	27. Manner of Beath 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Tim Inju		njury at Work?	28d. Describe ho	ow injury occurred	
Attendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be				I ☐ Yes 2 ☐ No	006 Landing (0)		
DIVISION tel or Attending is after death. ef Director: Afte	Certification:	4 Homicide determined	28e. Place of injury building, etc.	(Specify)	street, factory, offi	сө	City or Town	treet and Number or Ri n, State)	irai Houte Number,
To the Hospitel or within 24 hours after To the Funerel Directory	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exen	ysician: To the best of niner: On the basis of e and manner state	kamination and/o	eath occurred at the rinvestigation, in m	e time, date and pla ny opinion, death oc	ce, and due to the courred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the within To the comp	ž	29b. Signature and title of certifier		/	29c. Lic	ense number	2	9d. Date signed (Monti	h, Day, Year)
λ		pulling	11	ربا	JWV J	12302	5 h	rou 9	P C005
T		30. Name and address of person who							
		Frederic H.			Medical	Campus	Road, H	agerstow	ı, Md.
St: Regist		31. Date filed (Month, Day, Year)	82. Registrar'	s Signature	100				

			State of Maryland	/ Depa	artment of Health and rtificate of Death	Mental Hyg		15100	
			Decedent's Name (First, Middle, Last)			2. Date of Deat	h	3. Time of Death	
	Physici		ORVILLE E.	FARE	RINGTON	May 5	2004 Year	12:55PM	
	/Medic Examir		4a. Facility Name (If not institution, give street and питьег)		4b. City, Town, or Location of Dea		4c. County of Death		
	Exami		210 Nantucket Drive		Port Deposit		Ceci1		
	Funeral		5, Social Security Number 6, Sex 7. Age (In yrs. las		If Under 1 Year If Under 24 Hrs Months Days Hours Min			lace (State or Foreign	
	Director		239 – 38–2525	Yrs.		11/11/	1931 North	n Carolina	
	and *		Usuel Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	cation		11	0d. Inside City Limits	
	/anyli	ō			eposit			1 ☐ Yes 2√ENNo	
	the the 288-	Director	10e. Street and Number		10f. Zip Code	1	10g. Citizen of What Country?		
	3a or		210 Nantucket Drive		21904		USA		
	death ms 2	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of Hispanic Origin? ( f Yes, specify Cuban, Mexican, Pue	14. Race - Americ	an Indian,		
9	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show ta Mudical Exertines: wat its modified at	F	Armed Forces?  1 □ Never Married 2F⊒ Married 1 □ Yes 2 □ No			rto Hican, etc.)	Black, White,		
93		d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 □ Yes 2 <del>12 to</del> Specify:	14-5	Specify <b>w</b> hit	е	
5	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking	16b. Kind of Business/Inc	lustry	
121	oe filed al Hygi d other	ם	Elementary/Secondary (0-12) College (1-401 5+)				Construc	mt i on	
7			10 17, Father's Name (First, Middle, Last)	Truck	C Driver	me (First, Middle, M		201011	
au		Be	John Farrington			Barnes	,		
Maryland 21215-0036	should that Ment	၉		19b. Mailir	l ng Address <i>(Street and Number or F</i> i	lural Route Number.	City or Town, State, Zip	Code)	
Ma	ulth ar 27 is r trau		carrio Mao Farrington wife	210	Name to short Ton	D1-D-			
ē,	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra once.	100	Carrie Mae Farrington-wife  20a. Method of Disposition  20b. Place con control	ce of Dispo	sition (Name of natory or other place)	Date	Location - City or To	wn, State	
Ë	Pages nent of nnt: If it ury or o				Baptist Cem. 5/8	3/2004	Colora, MD		
Baltimore,	permit. Pages Department of Important: If if any injury or o		21. Signature of Funeral Service Licensee	- / 22	. Name and Address of Facility			17314	
m	Depa Impo any id		July Joules	Ha	rkins F.H.Inc	.,600 Ma	in St., De	1ta,PA	
			23a. / a.r. En / the disease, or complicitions that caused the death, so ck, or heart failure. List only on cause on each line.	o ot ent	er the mode of dying, such as cardia	c or respiratory arre	est,	Approximate Interval Between	
	Physician		Immodiate Cause (Final disease or condition		ancer			Onset and Death	
1	/Medical Examiner		resulting in death)  Due to (or as a consequent						
н	Examine	L	Sequentially list conditions, b.						
	bed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liecaeo or injury that initiated events	nce of):					
	and I-tran	Examiner	that initiated events c.  resulting in death) Last  Due to (or as a conseque)	nce of):					
760,	icate be executed physician and s the burial-transit	calE							
687	ficate physics the	olba	d						
Вох	leath certificate attending phy I for use as the	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance				23d. Date of delive	ry	
	death s atte d for	icial	in the past 12 months?  1 Ves 2 No.  1 Pregnant at time of deat		Ectopic pregnancy  Other (specify)		Month	Day Year	
P.O.	t the by the	hys	9 ☐ Unknown 9 ☐ Unknown						
	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	by P	Part II. Other significent conditions contributing to death but not resulti	ng in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to th	e cause of death?	
rd	w require been signated should b	edi				1 ⊠ Ye	s 2 □No 3 □ Proba	ably 4 □Unknown	
Records,	aw re as be 2 sho	plet				24a. Was ar	24b. Were autop	osy findings available inpletion of cause of	
Ä	The late his page	Completed				perform	ed? death? XNo 1 ☐ Yes		
of Vital	Physician: The law this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one			
>		2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	t 3 DOA Other: 4 Nursing	Home 5 Reside	nce 6 Other (Specify	)	
		on:	1 ☑Natural 5 ☐ Pending (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred		
sio	eat or:	catl	2 Accident investigation		M 1 Tyes 2 No	Cost I (Ch	and and the base on December	Control North	
Division	l or Attencafter death Director: in by the	Certification:	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office	City or Town	eet and Number or Rural , State)	Houte Number,	
	pital ours a eral (		29a. Certifier 1☑ Certifying Physician: To the best of my knowle	edge deatl	a occurred at the time, date and place	e and due to the ca	use(s) and manner as st	ated	
	24 hc 24 hc 8 Fun etely	Medical	(Check only 2 Medicel Exeminer: On the basis of examination one)						
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and time of certifier		29c. License number		d. Date signed (Month, L	Day, Year)	
	> F- Q		I Suchenting	, M.	DOU4781	3	May 6, 20	04	
	ĺn		30. Name and address of person who completed cause of death (Item 2	За) (Туре,	Print)				
	Ψ		Dr. Bashar Kara Kash ,			ake Dr.,	Bel Air,	MD	
	Sta		31. Date filed (Month, Day, Year)  MAY 1 2 2004  32. Registrar's Signatur		/				
	Regist	rar	1111 1 4 2004 America	D	Sparks -				

			For State Registrar	State of Ma	aryland .		artment of h			ental Hy	giene Reg. No.	004	1510	
	Dhysisi	on	Decedent's Name (First, Middle	, Last)						2. Date of De	eath Day	Year	3. Time of Dea	
	Physici /Medi		CHARLES			FI	FRMER			MAY	10	200	1 5:014	) M
}	Examir	ner	4a. Facility Name (If not institution,	give street and number)	1/	01/	4b. City, Town, o		of Death	1.	4c. Cou	inty of Death		
			The Johns	HOPLINS	Hosp	2/12/	If Under 1 Year	If Under	24 Hrs.	ity		N/A		
	Funeral Director		5. Social Security Number 212–82–0855	6. Sex 7. Age 1 ☑ M 2 ☐ F	e (In yrs. la\st	Yrs.	Months Days	Hours	Min	B. Date of Bi (Month, Da NOV	nn a <i>y, Year)</i> B <b>,</b> 1965	9. Birth	place (State or Fountry)	reign
			Usual Residence of Decedent					<u></u>		NOV.	, 1900	I III	ARYLAND	
	rylan		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Lin	_
	Be-f s	cto	DE SUS	SSEX	G	EORG	ETOWN						1 🗌 Yes 2 🔀	No
	vith th	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citízen		-	
	a 23s	erai	18984 Dupont B.	Lvd. 12. Was Decedent I	Fuer in U.S.	12.1		9947	-1-0 (0	· · · · · · · · · · · · · · · · · · ·		ed Sta		
	ter de	-un-	11. Marital Status 1 ☐ Never Married 2 ☑ Marri	Armed Forces?		13.	Vas Decedent of H Yes, specify Cub	an, Mexican	gin? (Spec 1, Puerto R	ican, etc.)	D- 14. F	Race - Amer Black, White		
93	2 hours after death with the Marylan atural', or Itema 23a or 28e-f show ical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2⊠No	Specify:			Spe	city: Wh	ite	
5-0	72 hours after death with the Maryland "natural", or Itema 23a or 28e-f show idical Examiner must be notified at	Completed	15. Decedent (Specify only highes		1	6a. Dece	lent's Usual Occup	ation	t of working	,	16b. Kind o	f Business/I	ndustry	
21		dr	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retire	d)		,				
2	filed within Hygiene. other than		12th 17. Father's Name (First, Middle, I	act)		Ele	evator Me			Circle Adiabatta	Elevat		gineerin	3
and	Q 22 D 2	Be		nes Farmer, .	Tag			10. MOLINE				name)		
Maryland 21215-0036	2 should by and Menta is marked sumatic ev	2	19a. Informant's Name/Relationsh			19b. Mailir	g Address (Street	and Numbe		h N. S		wn State 7	n Code)	
	nd 2 alth a 27 is r trau		Cindy Farmer	wife			Hernwoo				ck, MD	2116	_	
ore,	Pages 1 ar nent of Hea ant: If item;		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of natory or other place	- 1	Da		20c. Location			
Ē			1 ☑ Burial 2 ☐ Cremation  4 ☐ Demation 5 ☐ Other (Sp				-		у Мау	14, 2	004 G	ranit	e, Maryla	ınd
Baltimore,	permit. Departr Importa any nji		21. Signature of Funeral Service L	icense		22	. Name and Addre	ss of Facilit	v					
	202 20		Tanul (1)	ally	7	12	rrier-Qu 12 W. 01	d Lib	erty	Road	Winfie	ld :	MD 21784	
			22 . Pa /i. Enter the disease, or shick, or heart failure. List of	complications that of used only one cause of each fir	the death. D	Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician /Modical	1	Imme late Cause (Final diseal e or condition rest ting in death)	_a_SEPSI	5								ZDAY	5
	/Medical Examiner	-	, , , , , , , , , , , , , , , , , , ,	Due to (or as	10		-//						Marine Street Co.	
	1867.8	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as		35 <i>C(</i> ce of):	55						LWILL	٥
	d d ansit	Examine	cause. Enter Underlying that initiated events	С.										
, O	execen an		resulting in death) Last	Due to (or as	a consequen	ce of):								
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burlat-transit	licai		d.								_		
Ö	death certifica attending ph d for use as the	Physiclan/Med	IF FEMALE:	22- 16										
Box	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome  1 Live birth  4 Pregnant at	2 Fetal dea	ath 3□	Ectopic pregnancy Other (specify)	′				Date of deliv Month	ery Day Year	
P.O.	that the de led by the a detached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	time or death	. 3	Other (specify)	•			12			
	res that signed b	by Pr	Part II. Other significant condition	ns contributing to death bu	ut not resultin	g in the ur	derlying cause giv	en in Part I.		23e. Did t	obacco use co	ontribute to	he cause of death?	?
Vital Records,	w requires been sig should be	ed b	OBESITY, R	ESPIRATO	RY	FAI	LURE.			1 🗆	Yes 2 No	3 □ Pro	bably 4 ⊡Unkno	wn
ဝ၁ေ	e law re has bee je 2 sho	Completed	SPINAL PAR	ZALYSIS						24a. Was		b. Were aut	psy findings availa	able
œ	Th ate pag	E C								perfo	rmed?	death?	mpletion of cause	OI .
/ita	Physician: this certificated director,	Be	25. Was case referred to medical examiner?							Check only o				
of	Physi this c	٤	1 Yes 2 No	Hospital: 1 Pinpatie		Outpatien	3 DOA Oth	er: 4 🗆 Nur			dence 6 □0		fy)	
no	fter inel	tion	1 Matural 5 ☐ Pending		Year)	b. Time of Injury	28c, Injun Wor	yat k? Yes 2⊡N		d. Describe	how injury occ	curred		
Division	Attending er death. rector: After by the funer	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of Inju	ıry - At home,	, farm, stre		.03 201		f. Location (	Street and Nu	mber or Rur	al Route Number,	
ă		Certification:	4  Homicide	building, etc	c. (Specify)		,,			City or To	vn, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and pinion, deat	d place, and th occurred	d due to the at the time,	cause(s) and date and plac	manner as s e, and due t	itated. o the cause(s)	
	To the within 2. To the Complet	Me	29b. Signature and title of certifier				29c. Licens	e number			29d. Date sig	ned (Month,	Day, Year)	
	0		> Gmly S	drip, 02	- MI		RES	-0C	$\sim$		MAY	10,	2004	
	11		30. Name and address of person v	who completed cause of de	eath (Item 23	a) (Type,			22111					
	4		EMILY SCHOPICK	, JOHNS HOPI	KINS H	HOSPI	MAL, 600	NORT	TH WO	LFEST	REET, B	ALTIMO	RE MARYLAN	D
	Sta Registr		31. Date filed (Month, Day, Year)	MAY 1 2 2004	r's Signamire	1	Is do							
	ricgisti	· Car		THE T IN MUUT	per	are and	15 6400	1						

The Second Provided Control of Co			-	For State	State of Marylar		partment of H e <i>rtificate of I</i>				0.1	15-100
Richard  Ric				Registrar	*)	- 0	erimeate or i	Jean			U la	3. Time of Death
## Fedby Have (from shabeling to be shabeling to the shab			ın				Freeman		Month	Day		10:35 a <sup>M</sup>
Source   Combridge   Combre	2			4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
The control of the co				2605 Chapel Lake	Dr., #406							
Supplementary   Discounter				17	חא מחר				(Month, Day,	Year)	9. Birthpl	ace (State or Foreign
To State of Name And Provided Business (Name And Provided			-		0.5			<u> </u>	reb. 19	, 1919	wasi	ington be
State   Stat		yland		10a. State 10b. County	10c. Ci	ty, Town or	Location				10	
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State   Stat		eath v	eral			IS 1:			ecify Yes or No-			an Indian.
State   Stat	<b>'</b>	fter de	Fun		Armed Forces? 1 ☐ Yes 2 <b>XX</b> No	7.0.	If Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)	Black	c, White, e	etc.
State   Stat	98	ours a	þ	3 Widowed 4 Divorced	If Yes, Give		1∐ Yes 2 <b>XLX</b> No	Specify:		Specify:	BI	.ack
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State   Stat	12	within ane.	dm		College (1-4or 5+)			1)		Frozen	Food	le.
23a. Part I. Eriter the disease, or comflications that caused the death. Do not enter the mode of bring, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each time.  24b. Herming Land Approximate shock or heart fature. List only one cause on each time.  25c. List only one cause on each final disease or comflications that caused the death. Do not enter the mode of bring, such as cardiac or respiratory arrest, shock or heart fature. List only one cause on each time.  25c. List only one cause on each final disease or comflications that caused the death. Do not enter the mode of bring, such as cardiac or respiratory arrest, shock or heart fature. List only one cause on each time.  25c. List only one cause on each final disease or comflications that caused the death. Do not enter the mode of bring, such as cardiac or respiratory arrest.  25c. List only one cause on each final disease or comflications that caused the death. Do not enter the mode of bring, such as cardiac or respiratory arrest.  25c. List only one cause of the cause of th	0	filed y Hygie Sther	ပိ				TELK	18. Mother's Nam	e (First, Middle, M			15
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Fire sicinity  Medical Examiner  Medical Examiner  The case of head failure. List only one cause on each line.  Immediate Cause (final cause final cause (final cause (final cause (final cause (final cause final cause (final cause (final cause (final cause (final cause final cause (final cause (final cause (final cause (final cause final cause (final cause (final cause (final cause (final cause final cause (final cause (final cause (final cause (final cause final cause (final cause (final cause (final cause (final cause final cause (final cause (final cause (final cause (final cause final cause (final cause (f	Bal	Departing Department of the sany in gang in ga	E 1	21. Signature of Funeral Stylice Light	~~~		Hardesty 12 Ridge	Funeral 1 Y Avenue	Home P.	A. olis, M	D 214	01
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The composition of the composi				resulting in death)	Due to (or as a conse	quence of):	ho- 1	10081-	fr			7.34
The composition of the composi			6	if any learming to industriate	b. Dus to (or as a cones	quence of)	1145 /				-	Toger,
The composition of the composi	560	uted d ansit	m	cause. Enter Underlying Cause (Disease or injury	. 1	4yp	ex lipsic	Leurs	7			20+ yu
FFEMALE:   236. Was seededn't pregnant   1	oʻ	a exec an an rrial-tr	Exa	resulting in death) Last	Due to (or as a conse	quence bf):	V					U
FFEMALE:   236. Was seededn't pregnant   1	376	ate be hysici the bu	Ical		d							
State    State	_		a	IF FEMALE:	220. If yee outcome of pregn	anov					4 1 15	
State    State	Bo	eath c attend for us	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet	al death		,				
1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy findings available prior to completion of cause of death?   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy findings available prior to completion of cause of death?   1   Yes   2   No   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy findings available prior to completion of cause of death?   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy findings available prior to completion of cause of death?   1   Yes   2   No   1   Yes   2	0	0 0 0	hysl				- 1, ,,=					
24a. Was an autopsy performed perfor		s that gned k	y PI	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	e underlying cause giv	en in Part I.	23e. Did tob	pacco use contri	bute to th	e cause of death?
Part of the control	ord	equire en siç ould k							1 🗆 Ye	s 2 🗆 No	3 Proba	ably 4 Unknown
26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Manny of Death 1	ecc	tawr nas be	ple						autops	v . p	rior to con	sy findings available appletion of cause of
The state of the s	<u>~</u>	Th ate pag	Con						1 Yes 2	ned? d		2□ No
To the part of Death	Vit?	ilcian certifi rector	8	examiner?	Hospital:	7	Oth		-			
28. Could not be determined 28b. Place of Injury - At home, farm, street, factory, office 29b. Signature and title of certifier 29b. Signature and address of person, who completed cause of death, (Item 23a) (Type, Print) Yourn Towneys Gilen Burneys Gilen	of	Phys ir this aral di	-	1 192 5 7 140	28a. Date of Injury	28b. Time						)
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dudress of person who completed cause of death, (Item 23a) (Type, Print Yourn Towkys G. (En. Burnish  30. Name and address of person who completed cause of death, (Item 23a) (Type, Print Yourn Towkys G. (En. Burnish  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ion	nding ith. :: Afte e fune	atlor			Injur						
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30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) yourn Towars Glan Burnil  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	لبط	ospital hours and uneral	salCe									
30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) yourn Towars Glan Burnil  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		the H hin 24 the F nplete	Aedi	one)								
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State 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature		10		30. Name and address of person who a DALTIT S. Situ	completed cause of death (Ite	m 23a) (Typ	oe, Print Craci	Tower nid ?	s Gler	Bur	rni	e ,
THE TANK OF THE PARTY OF THE PA				31. Date filed (Month, Day, Year)	32. Hegistrar's Sign	ature	Some		- 0			,

			State of Maryland / Department of Health and N  1 - For State State of Maryland / Department of Health and N  Certificate of Death	Mental Hygier						
	Physic /Medi		WITHAM J. FORA	2. Date of Death Month	Pay 2004 3. Time of Death 2:32 PM					
	Examii Funeral	ner	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	(c) County of Deeth  (d)					
	Director		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	Sept 6 19	30 Pennsylvania					
	ours after death with the Marylan rat', or Items 23a or 28a-f show Exemirer mast be notified at	Director	MD Harlord Jarrettsville  10e. Street and Number  101. Zip Code	10g. (	1 ☐ Yes 2 ATNo  Citizen of What Country?					
	r death wit ems 23a o	Funerai D		pecify Yes or No-	14. Race - American Indian, Black, White, etc.					
5-0036	72 hours after death with the Maryland "netural", or Items 23a or 28a-f show calcal Examinst must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		specity: White					
2121	-	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  DIPLEMENTAGE  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	R	Kind of Business/Industry SHEEL SHEEL					
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event. Us M	To Be	17. Father's Name (First, Middle, Last)	e (First, Middle, Maide	PRAMUOUS OF TOWN State, Zip Code)					
-	00==		C. Rose Ford-wife 3133 Sharen Rd.	Sarrettes Date 200	Location - City or Town, State					
Baltimore	permit. Pag Department Important: I eny injury c		*4 Donation 5 Other (Specify)  21. Signature   Fineral Service Usensee   22. Name and Address of Facility EV	2004 MIL ans Fune	dale RIVER, MD					
	Physician		23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	or respiratory arrest,	Approximate Interval Between Onset and Death					
	/Medical Examiner	e.	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	d heart	failue years					
, 0	ate be executed hysician and the burial-transit	Examine	Due to (or as a consequence of):							
× 68760	n certificate be anding physic use as the bu	Medical	IF FEMALE:		years					
.O. Box	deati e atte	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year					
ords, P.	w requires that the been signed by th should be detache	ρλ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part!.	23e. Did tobacco	use contribute to the cause of death?					
of Vital Records,	The la ate has page 2	e Completed	OF IN- and other desired	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No					
N N	dis y	O B	examiner?	me 5 Residence	6 COther (Specific)					
Division of	ling After une	ation: T	27. Magner of Death 1 Natural 5 Pending 2 Natural 5 Pending (Month, Day Year) 2 Natural 1 Nestigation   28a. Date of Injury (Month, Day Year)   28b. Time of Injury Work?  M 1 Yes 2 No	28d. Describe how inju						
Divis	oital or Attandurs after deathurs after deathurs oral Director:	Certification:	building, etc. (Specify)	City or Town, Stat						
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in in	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, of the death occurred at the time, date and place, one)  Constitution of the death occurred at the time, date and place, one)  Constitution of the death occurred at the time, date and place, one)	ed at the time, date an	d place, and due to the cause(s)					
)	5 iš 5 2		29c. License number  29c. Lice	79 Ma	ate signed (Month, Day, Year)  Ly 6, 2004					
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ALBERT S. SUN, M.D. 1716 Harford Road Ste.  31. Date filed (Month, Day, Year)  32. Registrar's Signature.	105 Falls	ton MD 21047					
	Sta Registr		MAY 1 2 2004 Bern & Sporks							

Ford, William 031540

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:20 PM William H. Garrison may 9 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 23, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1XM 2 = F Virginia 1957 225-96-7569 46 Director Usual Basidence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthan "natural", or items 23a or 28a-f show the Modical Examinat must be rediffed at MD N/A Baltimore 1X Yes 2 □ No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2845 Chesterfield Avenue 21213 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinating. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify: Specify þ 3 Widowed 4 Divorced white Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Etementary/Secondary (0-12) 12 Pianist Music 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane E. Stinson Warren W. Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 2845 Chesterfield Avenue; Baltimore, MD 21213 Jenifer T. Garrison 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/17/04 Towson, MD 5 Other (Specify) \* 4 □ Donation 22. Name and Address of Facility Funeral Service Licensee 1050 York Road 21. Signature q etis Ruck Towson Funeral Home Towson, MD 21204 that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call tmmediate Cause (Final disease or condition resulting in death) Multi System Organ Failure Due to (or as a consequence of): **Physician** day /Medical Respiratory
Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Bronchitis attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Carcer Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the a detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. p 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 200 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ပ 2 ER/Outpatient 3 DOA \$IU 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT24 38946-D18 may 09, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University Parkway, Baltimore MD 21218-2895 Chelsia Varner, MD 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

		State of Maryland /	Department of Health and N Certificate of Death	Mental Hygiene 2 0 0 L	15105
	Physician /Medical		Graber	2. Dete of Deeth Month Day Year May & 200 4	3. Time of Death  0200am
	Examiner	4a Fecility Neme (If not institution, give street and number)	4b. City, Town, or Lo		
		Stella Maris @ Mercy Hopice Cent			
ž	Funeral Director	5. Social Security Number 6. Sex 1 ☐ M 2CXF 7. Age (In yrs. lest bit 218-28-8481 71	Yrs. Months Days Hours Min.	(Month, Day, Year) Coun	lace (State or Foreign ltry) Cy1and
	and w	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Tow	n or Location	1:	0d. Inside City Limits
	Sa-f shooting	Maryland Baltimore	Colgate		1 ☐ Yes 2XXNo
	ifier death with the Ma r ifems 23a or 28a-f s niner must be notified Funeral Director	10e. Street end Number   8030 Gough Street	10f. Zip Code 21224	10g. Citizen of What Coun United Stat	
020	72 hours after death with the Maryland natural", or items 23a or 28a-f show diest Examinet must be notitled at steed by Funeral Director		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Specify:	
Baltimore, Maryland 21215-0020	be filed within 72 hours af Ital Hygiana. d other than "natural", or event, the Medical Exam Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		•
d 2	Hygia Hygia ther t		Housewife	Own Home (First, Middle, Maiden Surname)	<u>}</u>
ylan	should be filed ind Mantal Hygis markad other i umatic event, if	William Frederick Smith	Marga	aret Elizabeth Warne	
, Mar	tra tra		o. Mailing Address <i>(Street and Number or Rura</i> 505-02 Eastview Terra		Code) 21009
nore	permit. Pages 1 an Department of Haai Important: if Itam 2 any injury or other DRCB.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of iny, crematory or other place)	Date 20c. Location - City or Tox	
alti-	permit. Pag Department important: any injury once.	4 □ Donation 5 □ Other (Specify) Oak La  21. Signature of Funeral Service Licensee	awn Cemetery 5/8/200	The second secon	
<u>~</u>	Per Sany	1 Withat Illein	7922 Wise Ave. Dun		
1	Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a			Approximate Interval Between Onset and Death
	icate be executed physician and s the burial-transit	Sequentially list conditions, if any leading to immediate	consequence of):		
68760,	e be ey sician e buria	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events			
			consequence of):		
Ď.	death e atta ed for	Part II. Other significant conditions contributing to death but not resulting in	o the underlying cause given in Part I	23b. Did tobecco use contribute to	the cause of death?
О	that the daath certi ed by the attanding datached for usa a	The state of the s	This directlying cause given in that it.		ably 4 Unknown
Records,	The law requires that the death certificate be executed atta has been signed by the attanding physician and paga 2 should be detached for use as the burial-transit Completed by Physician/Medical Examir			performed? avai	re autopsy findings ilable prior to apletion of cause eath?
	The ata h			1 Ves 2 No 10	Yes 2□ No
Vital	clan: entific ector.	25. Was case referred to medical examiner?		(Check only one)	
ō	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Medical Certification: To Be Com	27. Manner of Deeth 28e. Dete of Injury 28b. 1		me 5 Residence 6 A ther (Specify) 28d. Describe how injury occurred	hospice.
Divisi	tal or Attending P rs aftar death. al Director: Attar led in by the funers  Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street and Number or Rurel City or Town, State)	Route Number,
	To the Hospital within 24 hours a To the Funeral if completely filled Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	, death occurred at the time, date and place, a d/or investigation, in my opinion, death occurre	and due to the cause(s) and manner as sta	ited. the cause(s)
	Vithin Vithin To the Somple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, D	lay, Year)
	1	Du llung -	D40854	5/6/20	04
	6	30. Name and address of person who completed cause of death (Item 23e) (	Type, Print)		
		Davib, Riseberg 301 ST.	DAULPL Balkir	nore md. Zi	202
	State Registrar	31. Dete filed (Month, Day, Year) 32. Registrar's Signature	Society		

GRABER, MARIYN

02	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		4 100	partment of Health and N ertificate of Death		ene g. №. 2004 15106
	Physici		Decedent's Name (First, Middle, Last)     ASHLEY JEAN GARLITZ		2. Date of Death Month May 1,	3. Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, give street and number) Memorial Hospital	4b. City, Town, or Location of Death Cumberland	<del></del>	4c. County of Death Alleghany
	Funeral Director		5. Social Security Number  233-11-2855  Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Aug. 20	year) 9. Birthplace (State or Foreign Country) 1975 Mary Land
	s after death with the Maryland , or Items 23a or 28a-f show iner i ust be retilied al	Director	10a. State			10d. Inside City Limits 1 □ Yes 2 🛣 No
	ath with th		10e. Street and Number  1012 Trenum Drive	10f. Zip Code 26726	10	g. Citizen of What Country? USA
9036	n	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2X No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	be filed within 72 hatal Hygiene. Id other than "natuavant, Ine Madical	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of work o. DO NOT use retired) omemaker	ring 1	6b. Kind of Business/Industry  Own Home
yland	12 should be filed within 'n and Mental Hygiene.' 7 is markad other than "raumatic avant, the Max	To Be (	17. Father's Name (First, Middle, Last)  David E. Harr, Jr.	Yvonr	e <i>(First, Middl</i> e, M ne J. Kep	linger
	s 1 and 2 should f Health and Men tem 27 is marks othar traumatic		Jeremy S. Garlitz/ Husband 10	illing Address (Street and Number or Run.  12 Trenum Drive Ke	eyser, WV	26726
Baltimore,	Page: nent o ant: If ury or		1 X Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Potomac	rematory or other place)  Memorial Gardens 2	1ay 7 2004	Oc. Location - City or Town, State  Keyser, WV
Balt	permit. Departr Importa any inj		21. Signature of Funeral Service Lice see	<sup>22. Name and Address of Facility</sup> Smi 85 S. Main Street	ith Funer Keyser,	al Home WV 26726
8760,	Physician /Medical Examiner but sician and physician and sicial function and sicial fu	dicai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	injuris		Interval Batween Onset and Death
P.O. Box 6	The law requires that the death certific tite has been signed by the attending r page 2 should be detached for use as	Physician/Me		3 ⊟Ectopic pregnancy □ Other (specify)		23d. Date of delivery Montt. Cay Year
	v requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Vital Records,		Completed			24a. Was an autopsy performe Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vit	nding Physici ath. r: After this cer ie funeral direc	Certification; To Be	25. Was case referred to medical examiner?  **C Yes 2 No	ent 3 DOA Other: 4 Nursing Holor of 28c. Injury at Work? 1 Yes 2 No	28d. Describe how Passacyler of	motor cycle struck
Divi	To tha Hospital or Atte within 24 hours after de Yo tha Funeral Directo completely filled in by th		29a. Certifier  (Check only  28b. Place of Injury - At home, farm, shuilding, etc. (Specify)  29c. Certifier  (Check only  28c. Place of Injury - At home, farm, shuilding, etc. (Specify)	ath occurred at the time, date and place	Keyser, and due to the cau	et and Number or Rural Route Number, State) Route 22 0 27 13446114
	To tha H within 24 To tha F complete	Medical	29b. Signature and title of certifier  Zalunullah ACT	29c. License number  O.C.M.E.	290	a and place, and due to the cause(s)  Date signed (Month, Day, Year)  ay 2, 2004
	12		30. Name and address of person who completed cause of death (Item 23a) (Type 24B1ULLAH ALI	e, Print)		e, Maryland 21201
	Sta Registr	· * · · · ·	31. Date filed (Month, Day, Year)  MAY 1 2 2004  32. Registrar's Signature	boards :		

			1 - For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth a D <i>eath</i>	and Men		iene2 0	04	1510	7
	Physici	an	Decedent's Name (First, Middi		erite C	. Given	S			Date of Deat Month	h Day 9, 2004	Year	3. Time of Deat	th P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of	of Death	may	4c. Count		8:14	P
	Exami		Montgomery Hos	pice Case	y House		Rockvi	l1e			Monte	omer	J	
	Funeral Director		5. Social Security Number 143-01-6519	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 85	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth Month, Day,	Year)	9. Birthp Cour	place (State or Fore	eign
			Usual Residence of Decedent						00	7,	1910	New .	Jersey	
	irylan ihow	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	Od. Inside City Lin	
	8e-f	Director		gomery		Ве	thesda						1 □ Yes 2 €	No
	with the	Pire	10e. Street and Number	1 D - 1			10f. Zip Code	016		10	0g. Citizen of		•	
	ns 23	Funeral	5322 Wakefiel		cedent Ever in U	J.S. 13. \		816 spanic Orio	in? (Specify	Yes or No-	Unite	d Sta		
320	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "natural", or items 23s or 28e-f show avent, the Madical Examitral must be multified at	by Fun	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	ined Armed F	forces? 2 <b>X</b> No live		Was Decedent of Hi f Yes, specify Cubai 1 □ Yes 2 1 No	Specify:	, Puerto Rica	in, etc.)		ck, White,		
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Ĕ	t. Pages rtment of l rtant: If It njury or o	Н	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  `4 ☐ Donation 5 ☐ Other (Specify)  St. Gertrude Cemetery 2004 Colonia, New J										Jersey	
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not ente	er the mode of dying	, such as c	cardiac or res	spiratory arre	st,	OL =	Approximate Interval Between	
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מ	death certif e attending od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live	birth 2 ☐ Feta	aldeath 3⊑	Ectopic pregnancy Other (specify)					ite of delive onth	ny Day Year	
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coras	w require been sii should t		Congestive Hea	art Failu	re				- "	1 🗌 Yes	s 2 🕅 No	3 Prob	abiy 4 □Unkno	wn
<b>D</b>	ne law r has be ge 2 sh	Completed	Status Post Co	oronary A	rtery B	y-Pass	Graft			24a. Was an autopsy	,	prior to con	osy findings availa	ble of
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VII	Physician: r this certificaral director,	o Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☒ No	Hospital:	Unaction 2	7 FD (O-1414	Othe			eck only one				
0	iding Phyaician: th. After this certifical funeral director, p	on: To	27. Manner of Death	28a. Date	Inpatient 2	28b. Time of	t 3 DOA Ome 28c. Injury Work	at at	28d.	Describe hov	v injury occur	ier ( <i>Specit</i> y red	Hospice	7
VISION	ath. ath. rr: Aft	atlo	1 ☑Natural 5 ☐ Pendin investi	gation	nth, Day Year)	Injury		es 2 🗆 N	lo					
<u> </u>	r Atte	Certificati	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be lined 28e. Plac build	e of Injury - At h ling, etc. (Speci	ome, farm, stre	eet, factory, office		28f. L	ocation (Stre	eet and Numb State)	er or Rura	Route Number,	
ב	pitel o	Ce	CO. Cartifica 4 M Cartiful	- Observation - To III					ŧ					
	To the Hospitel or Attending within 24 hours efter death.  To the Funeral Director: After completely filled in by the fune	edical	2 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	with To t	Σ	29b. Signature and title of certifie	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			29c. License			29	29d. Date signed (Month, Day, Year)			
	\			Lih	Q			9470		]	May 10	, 200	4	
	P		30. Name and address of person				•	. 77	,		-		0 =	
	Sta	te	Eugene P. Libre 31. Date filed (Month, Day, Year)	32. I	Registrar's Sîgna	atur	cut Avenu	e, Ke	nsingt	con, M.	aryland	d 208	95	
	Registr	_	31. Date filed (Month Day, Year) MAY 1 2 20	J4 Den	1	D A	park							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** WILLIAM GARRISON MAY 08, 2004 8:45 A. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Year) 1 M 2 □ F 7-18-655 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f ehow the Wedical Examiner must be notified at 1 ☐ Yes 2 No Director MD Martoro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21050 1600 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpoll Independent Elementary/Secondary (0-12) College (1-4or 5+) lik marked other 19. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Jare ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, of Health and 20a. Method of Disposition -Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite May 1 ☐ Burial 2 ☐ Cremation 3 Removal from State \* 4 □ Donation 5 ☑ Other (Specify) FuneralC MOGEL-AIR 21. Signature of Foneral Service License 22. Name and Address of Facility Vans rapal eny in 11050 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 18aya /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and thed for use as the buriat-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9☐ Unknown 9 ☐ Unknown δ peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 110 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has director, page 2 autopsy performed? certificate 2: NO 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pe 8,2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUEL LAZATIN 8 LAW STREET ABERDEEN, MD. 21001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 2 2004

		1 - For State Registrar  1. Decedent's Name (First, Middle,		aryland / Dep <i>Ce</i>	rtificate of	Death		200L	3. Time of Dea
Physici /Medic Examin	al	Rolf H. Hert  4a. Facility Name (If not institution, Oakcrest Vil	tsgaard give street and number)		4b. City, Town, o	or Location of Death	Month April 30	4c. County of Dea	11:45 P
Funeral Director			6. Sex 7. Ag	e (In yrs. last birthday 81 Yrs.			8. Date of Birth (Month, Day, ) June 12,	Baltin 9. Bir 1922 Min	
Sa-f show	ctor	10a. State 10b. County MD Baltin	nore	10c. City, Town or L Baltimo					10d. Inside City Li
23a or 2	rai Dìre	10e. Street and Number 8810 Walther Bl	.vd #1514		10f. Zip Code 212	236	100	g. Citizen of What Co USA	ountry?
Department of Healin and Mediat Hygiene.  The mode and a second s	d by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? d .1 \( \text{\ti}\text{\texi{\text{\texi{\text{\texi{\text{\text{\texi{\text{\texi{\text{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi\tinter{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\tet		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: 7	encan Indian, te, etc. Thite
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ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1	ecify)	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ca)		c. Location - City or	
eny inju		21. Signature of Funeral Service Line Rona I. S.	Wade Dire	ctor St	2. Name and Addre	ss of Facility	655 W. B	altimore	Straet
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by the atter ached for u	hysicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			Month	,
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DHMH 17 Rev 1/2001

Rolf Hertsgaard

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			Registrar  1. Decèdent's Name (First, Middle, L.	ast)		Cei	runcate of	Dealli	2. Date of D	Reg. N	lo. 400	3. Time of Dear	th
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	amin		4a. Facility Name (If not institution, gi				4b. City, Town, o	r Location of Deat	th	4	c. County of Dea	ith	
			Edenwald Care C 5. Social Security Number 6.		(In vrs	last birthday)	Towson If Under 1 Year	If Under 24 Hrs	. 8 Date of Bi	E	Baltimor	e thplace (State or For	oian
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and w	1452		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	ncation					10d. Inside City Lin	nits
Maryia f sho	is Dai	ភ្ជ	MD Baltimo	re		wson	Joanor					1 □ Yes 2 □	
th the	nou a	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C	ountry?	
if E, INIAL YIAILU ZIZIO-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland f H-aith and Mental Hygiene. item 27 is marked other than "neturel", or items 23a or 28a-f show	d last	ral	800 Southerly R				21286				JSA		
ter de	naru	Funeral	11. Marital Status  1    Never Married 2   Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕅 No		.S.   13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	0-	l 14. Race - Am Black, Whi		
ours at	Exam	<u>ک</u>	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1⊡Yes 2.2XINo	Specify:			Specify: W	hite	
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aryiai should b ind Menta s marked	atic e	10	John Hock					Lulu	House				
VICI 12 sh h and 7 is m	traum		19a. Informant's Name/Relationship		onne		ng Address (Street						
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Pages nent of	iry or		1 💆 Burial 2 □ Cremation 3 l  `4 □ Donation 5 □ Other (Spec		Ba	1timor	e Cemeter	°y 5/15	5/04	Ba	ltimore,	MD	
Dattinore, Mispermit. Pages 1 and 2 Department of Health a	any inju once.		21. Signature of Funeral Service/Lice	mego		22	2. Name and Addre	ss of Facility			1050 Yo	rk Road	
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			23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	/ cause on each line	6.	ni. Do not ent	er the mode of dyli	ig, such as cardia	c or respiratory a	irrest,		Interval Between Onset and Death	
Physic /Med			disease or condition resulting in death)	a. Due to (or as a	conseq	uence of):	NIA					Inn	
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I necolds, F.O. box oo The law requires that the death certifical ate has been signed by the attending ph	d for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Feta	Ideath 3□	Ectopic pregnancy Other (specify)	<i>'</i>			23d. Date of de Month	Day Year	
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hysici his ce	I direc	ToB	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	nt 2 🗆	ER/Outpatien		4 Nursing F	lome 5□Resi	dence	6 □Other (Spe	cify)	
off of clang P th.	funera	ilon:	27. Manne of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	Wor		28d. Describe	how inju	ury occurred		
Attence deatlert	by the	ifica	3 Suicide 6 Could not	be 28e. Place of Injur	ry - At ho	ome, farm, str						ural Route Number,	
rs after	ed in t	Certification:	4  Homicide determine	building, etc.	. (Specin	y) 			City or To	wn, Stai	re <i>)</i>		
UIVISION ON VITAL MET TO THE HOSPITE OF ATTENDED PHYSICIAN: The law within 24 hours after death.  To the Funerel Director: After this certificate has in	etely fill	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner state	examina	wledge, death tion and/or inv	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s date ar	s) and manner as nd place, and due	stated. to the cause(s)	
To the within To the	сотр	Me	29b. Signature and title of certifier	0			29c. Licens			29d. Da	ate signed (Mont	h, Day, Year)	
	1	1	Inch &	non			Print) CAMP	2783	y	רי	Ay 11	12004	
6	11		30. Name and address of person who	completed cause of de	ath (Item	1 23a) (Type,	Print)	מפחרו	n Rr	) ;	LINIT	7007,0	4
	Sta	te	31. Date filed (Month, Day, Year)	37. Registra			1 .						_

			1 - State	State of Ma	aryland / Dep <i>Ce</i>	ertificate of i		ind Menta		20116	15111
			Registrar  1. Decedent's Name (First, Middle, I	Last)			Douin	2. Dai	Reg. N	0.	3. Time of Death
	Physici			IL Holb	rook			Mo		ay Year	e om e e e e
	/Medic Examin		4a. Facility Name (If not institution, g		, , , ,	4b. City, Town, or	r Location of			c. County of Deat	1000
	Examin	er	Baltimore Reha		Total alad Com		imes		"		
	Function	-14			(In yrs. last birthday		If Under 2	4 Hrs. 8. Dat	e of Birth	N/A 9. Birt	thplace (State or Foreign
ŀ	Funeral Director		219-30-1292	163 M 2016	58 Yrs.	Months Days	Hours	Min. (Mo	onth, Day, Year	')   Co	aryland
			Usual Residence of Decedent					Det	J. 1/1/	JJJ   110	iLyland
	ylanc now		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Mar-fal	ţ	Maryland Bal	timore		Du	ndalk				1 Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code		-	10g. C	itizen of What Co	ountry?
	h wit		7400 Old Battle	Grove Road	l		2122	22	U	nited St	tates
	deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.	. Was Decedent of H If Yes, specify Cuba	ispanic Orig	in? (Specify Ye	s or No-	14. Race - Ame	
ထ္	after or Its	F	1 Never Married 2 Married		lo	1 ☐ Yes 2 ☑ No	Specify:	ruello nicali,	etc.)	Black, White	e, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vthar than "natural", or Itams 23a or 28a-f ahow ant, tre Madical Examition mat Le notified at	d by	3 ☐ Widowed 4 € Divorced	Year or Dates:		1 163 2 A 110	эрвспу.			Specify:	White
5	72 h natu	Completed	15. Decedent's (Specify only highest of		(Give	edent's Usual Occupa	during most	of working	16b. I	Kind of Business/	Industry
2	ithin Be.	ldu	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired	1)				
7	ygier ygier har ti	ပိ	8 Years		P	ainter				onstruct	ion
ind	should be filed withir nd Mental Hygiene. markad othar than matic avant, I.e.M.	Be	17. Father's Name (First, Middle, La					's Name (First,		,	
<u>X</u>	should be ind Mental s markad o umatic ava	2	Jay B. Holbrook					azel Max			
Maryland	2 sho		19a. Informant's Name/Relationship			ling Address (Street a 2 Old Bat					
	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If itam 27 is marked othar than "natural", or Itams 23a or 28a-f ahow or othar traumatic avant. It a Modical Extending the motilling at		Matthew A. Horn	lung / Son			CTE GI	-		dalk, MD	
0	ges 1 t of h If ita or ot		20a. Method of Disposition 1 Marial 2 ☐ Cremation 3	☐Removal from State	1	amatory or other plac		Date	20c. L	ocation - City or	Iown, State
Ē	. Pa tmen tant: jury		Donation 5 ☐ Other (Spec			Cemetery	,				, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.		21. Sign ture of Funeral Service Lic	ensee	00 3	22. Name and Address Duda-Ruck	ss of Facility Funer	al Home	e of Du	ndalk, I	inc.
_	0 □ = @ O		000	- au		7922 Wise	Ave.	Dundal	k, Mar	yland 2	1222
П			23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that caused by one cause on each lin	the death. Do not er ie.	nter the mode of dyin	g, such as c	ardiac or respir	atory arrest,		Approximate Interval Between
H	Physician	0. 1	Immediate Cause (Final disease or condition	Bra							Onset and Death
				10/	in met	astase_	S				3 HUDITAS
į.	/Medical		resulting in death)	Due to (or as a	a consequence of):						3 Months
i.	/Medical Examiner		Sequentially list conditions	Due to (or as a	a consequence of):			eoma			3 months 4 years
	Examiner	iner	Sequentially list conditions	Due to (or as a	a consequence of):			eoma			3 months
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			For State Registrar	State o	f Maryla	nd / Depa <i>Cei</i>	artment of F	lealth Death	and M		giene Reg. No.		) l <sub>4</sub>	15	112
L		x .	1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea	ath		,	3. Time o	f Death
Н	Physici			Alice An	derson	Harmo	n			Month May	Day 9	200	<sup>reer</sup> )4	1:08	РМ
	/Medic Examin		4a. Facility Neme (If not institution	n, give street and nui	mber)		4b. City, Town, o	r Location	of Death		4c.	County of	Death		
		456	1017 Back Bay	Beach Roa	d		West R	iver			An	ne Ar	und	e1	
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h			lece (State	or Foreign
в	Director		577-24-1038	1 □ M 2 🛱 F	81	Yrs.	Months Days	Hours	IVIII.	January	22, 1	923 M	ary]		
	P		Usual Residence of Decedent												
	unylar show		10a. State 10b. County		100.0	City, Town or Lo							11	Dd. Inside C	
	Ba-f	cto	3	Arundel		West R	iver							1 🗀 1 62	2 <b>∑</b> No
	or 2	Director	10e. Street and Number				10f. Zip Code				10g. Citi:	zen of Wh	at Coun	try?	
	23a	ra	1017 Back Bay				20778					ited			
	r de:	Funeral	11. Marital Status	12. Was Deci	edent Ever in rces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	lispanic Or an, Mexica	rigin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	.   1	<ol> <li>Race - Black,</li> </ol>	America White, e		
36	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Madical Examinat must be notified at	ΥF	1 ☐ Never Married 2 Married	If Yes, Gir	/e		1 □ Yes 2 No	Specify	:			Specify:	Wh	ite	
00	ural.	Completed by	3 Widowed 4 Divorced		ates:	1 10: 5									
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22	Hygie Hygie Sther		17. Father's Name (First, Middle,			COILLI	act spec.		-	(First, Middle,			0016	Timen	, L
and	d tal	Be	Gerhard T. And						h Sti	•	14161011	Ourriaine)			
2	should to	10	19a, Informant's Name/Relations			10h Mailir	ng Address (Street				r City or	Tour Ct	ato Zia	Cadal	
Ma	d 2 sho th and 7 is mu traum		Alan J. Harmon			1	Harmony I								710
e,	1 and 2 Health 16m 27		20a. Method of Disposition	7 5011	20b.	the property of the con-	sition (Name of	-	-			y La II u cation - Ci			10
ŏ	gas nt of l		1 ☐ Burial 2 X Cremation		State	cemetery, crer	natory or other plac	1	May 1				-		
ţ	t. Pa rtmer rtant rjury		`4 □Donation 5 □Other (S		Mor		rematorium,		2004					rylan	d
Baltimore, Maryland 21215-0036	permit. Pagas 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service	Barn 4 ta	MO1	305 Rối 300	Name and Address Dert A. Pur D West Mont	mphrey tgomer	"Funei y Aver	cal Home/ nue, Rock	Rock Ville	ville, Mar	Inc yland	20850	-2805
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	aused the dea	ath. Do not ent	er the mode of dyin	ng, such as	cardiac o	r respiratory ar	rest,			Approximat Interval Bet	tween
	Physician		Immediate Cause (Final disease or condition		1 = 14	Non	el							Onset and	Death
	/Medical		resulting in death)	Due to	or as a conse	MON equence of):								1000	
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100	D =	ner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying	Due to	or as a conse	iquentes af):							- 17		
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9	ntific ing pl	Med	IF FEMALE:					10			- 1				
Box	attending for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	come of pregi		Ectopic pregnancy	,			2	3d. Date o			Vans
	ne dea the at hed fo	sici	1 ☐ Yes 2 Ø No	4☐Pregn 9☐Unkno	ant at time of	death 5	Other (specify)					Month		Day '	Year
P.0	that the di ed by the detached	by Physician/Me	9 Unknown												
Records,	8 G 9	pd by	Part II. Other significant condition	ons contributing to di	eath but not re	esulting in the ui	nderlying cause givi	en in Parti	l. 	23e. Dia ta		/		e cause of c ably 4 □l	
CO	w requir been si should	Completed								24a. Was	30	24b. We	re auton	sv findings	available
Re	he lav e has age 2	щ								autop perfor	med?	₫ea	ith?	sy findings apletion of c	ause of
Vital	in: T ifficat or, pa		25. Was case referred to medica					00 01	4 D45		2/1 No	1	Yes :	2 2 No	
	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2[	☐ ER/Outpatien	t 3 DOA Othe	0.00	ursing Hor	(Check only or			10		
of	Phy ir this srai d		27. Manner of Death		of Injury	28b. Time of	28c. Injun	y at		ne 5 Pesid 28d. Describe h			(Ѕреспу,	,	
on	ding th: Afte	ţ	1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi	.3	th, Day Yeer)	Injury	Worl	k? Yes 2⊡			, ,				
Division of	Attendi death. ctor; A y the fu	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At	home, farm, str	eet, factory, office			28f. Location (S	treet and	Number (	or Rural	Route Num	iber.
Ö	after Dire	Certification:	4  Homicide	buildi	ng, etc. (Spec	city)				City or Tow					
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifyir	ng Physician: To the	best of my kr	nowledge, death	occurred at the tim	ne, date ar	nd place. a	and due to the	ause(s)	and mann	er as sta	ited.	
	24 F e Fu	edical	(Check only 2 Medical one)	Examiner: On the b	asis of examin ner stated.	nation and/or inv	restigation, in my of	pinion, dea	ath occurre	ed at the time, o	date and	place, and	due to	the cause(s	.)
	Coth mithin Coth cmpl	Me	29b. Signature and title of pertifie				29c. License	e number		2	29d. Date	signed (/	Month, E	ay, Year)	
	> F 0		1/4	BY11/	N		Dog	2517	201		Ma.	11	) ) /	00	
	0		30. Name and address of person	who impleted caus	e of death (Ite	em 23a) (Type	Print)	1	/ _ (		79	10	, , ,	7	
	`		Kenny & Kin	of MO	400	Be51	gente Pe	ويرم	Sam	2300	A	nn	lis	MD	2140
K.	Sta Registr		MAY 1 2 200		egistrar's Sigr	January A	parks					,			

			For State Registrar	State of Maryland /	Department of Health and Certificate of Death	d Mental Hygien	71114	15113
	Physici /Medi	al	1. Decedent's Name (First, Middle, Last)  HORN 4a. Facility Name, (If not institution, give s	Hyde	4b. City, Town, or Location of D	2. Date of Death Month	Day 2004  Lc. County of Deeth	3. Time of Death 3:35/M
	Examir Funeral Director	ier	Long View Nur  5. Social Security Number 6. Sex	sing Home	mancheste	r	Carrol  9. Birthpl	ece (State or Foreign try)
	D	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Carrol	1/ Co, 10c. City, To	own or Location AChester	10419 1,11	10	Od. Inside City Limits  1 Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, the Maryland Execution Land by rightfied at once.	Funeral Director	10e. Street and Number.  3306 Kennsing  11. Marital Status	Thon Square 2. Was Decedent Ever in U.S.	10f. Zip Code 2/1/0 Z		Citizen of What Count S	A.
5-0036	hours after d tural', or Item	by	t Never Married 2 Married 3 Vidowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin if Yes, specify Cuban, Mexican, Pi  1 ☐ Yes 2 No Specify:	4	Specify: White, e	inte
2121	filed within 72 Hygiene. other than "nai	Completed	(Specify only highest grade		Sa. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Secretary	working	AT+T	ustry -
Maryland	2 should be fi and Mental H is marked ot sumatic ever	To Be	17. Father's Name (First, Middle, Last)  Tames Her  19a. Informant's Name/Relationship (Typ.	2/7 1	nb. Mailing Address (Street and Number or	ural Route Number, City	e Pet	erson Code)
more, N	Pages 1 and innert of Health out: If Item 27 ary or other tr		20a. Method of Disposition  A Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	nome:	of Disposition (Name of	Date 20c. I	anchester, Location - City or Tov TMONIUM.	
Baltii	permit. Pag Department Importent: i any injury o		21. Signature of Funeral Service License	· Jan, Dr.	Name and Address of Facility REACE THE ATTEM 2325 YORK P.d.	tives funer	im, MD.	21093
	Physician /Medical		shock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	tribus that caused the death. Discusse on each line.  Due to (or as a consequence)	o not enter the mode of dying, such as card	Cun Les		Approximate Interval Between Onset and Death
3760,	ate be executed hysician and he burial-transit	ical Examiner	Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence				
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely liked in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death 9 Unknown	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	y Day Year
Records, P.	equires that en signed b ould be deta	by	Part II. Other significant conditions conf	tributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the	a cause of death?
al Reco	n: The law r ificate has be pr, page 2 sh	Completed	H 130			24a. Was an autopsy performed?	prior to com	sy findings available in including spletion of cause of the spletion of cause
Division of Vital	iding Physicia th, : After this cert : funeral direct	tion: To Be	examiner?		0.1	Death (Check only one)  Je Home 5 Residence  28d. Describe how inju		
Divisi	ital or Atter urs after dea rel Director lled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street a City or Town, Stat	te)	
	the Hosp thin 24 hou the Fune mpletely fi	Medical	29a. Certifier 12. Certifying Physic (Check only one) 2 ☐ Medical Exemin 29b. Signature and title of certifier	er: On the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc 29c. License number	curred at the time, date an	id place, and due to t	the cause(s)
	7.848		· aprino	ya an	1 5770	5 5	ate signed (Month, D	04
	`		30. Name and address of person who cor	+ 349 mali	Wilm DR, HRS	tminstel	10021	157
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year MARIE **Physician** HELMA TOFFMAN . 2004 MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours 1 ☐ M 2 💢 F -12-2248 MARYL Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or items 23a or 28a-f show directors be notified at 1 ☐ Yes 2 No BALTIMORE ARKVILLE **Funeral Director** ARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code BLVD, APT4210 21234 SA WALTHER 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 No 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No ō Specify: Specify: The Medical Exter-WHITE Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) RETARY DYOL traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be H.H. DHAUGHNESSY JARIE DIVAC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21234 BLVD APT 4210 PARKVILLE HUSBAND Health tem 27 TEORGE WALTHER : If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
CARRISON FOREST
VETERANS CEMETRY MAY 17, '04 20c. Location - City or Town, State 20a. Method of Disposition ō 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. GARRISON 4 ☐ Donation 5 ☐ Other (Specify) VE 22. Name and Address of Ficility 21. Signature of Funeral Service Licensee EVANS MEMORIES HAPEL OF 8800 HARFORD RD, PARKVILLE, MD 21234 23a. Part1. Enter the disease or complications that caused the geath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final / disease or condition resulting in death) Pnysician DIVERTICULITIS /Medical Due to (or as a consequence of): **Examiner** LEFT HYDRONEPHROSIS DAYA Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed DNEMIO Due to (or as a consequence of): Box 68760. Physiclan/Medlcal <u>PREVIOUS CEREBROVASCULAR ACCIDENT</u> attending p IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, β 1 Yes 2 No 3 Probably 4 Minknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 **2** No 1 🗌 Yes Vital 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No of this funeral 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending Division 1 Accident 5 Pending investigation death, 1 ☐ Yes 2 ☐ No Director: in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 \( \text{Homicide} \) within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number va 15 25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7671 OS

DHMH 17 Rev 1/2001

State

Registrar

OS M.

1 2 2004

TOWSON MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2:30AM Michele 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ritchip Hospice
7. Age (In yrs. last birthday)
39 Yrs. Joseph 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F 219-88-1983 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Nedical Exeminal must be notified at Baltimore 1 Tes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA Court 21237 Gemini Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Š Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If itam 27 Is markad othar than " Elementary/Secondary (0-12) College (1-4or 5+) Busines 112 Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HUFF, SR. Edward Brenda Care 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) + Rosedale MD 21237 Novene In's HUFF Sistex 10 Gemini 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 9 SacraedHeart Catholic 5/14/04 • 4 □ Donation 5 □ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate disease or condition Immediate Cause (Final disease or condition resulting in death) Acquired Physician immune deticiency /Medical Due (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 2 ☑ No 2 filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funaral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical ro the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Tso MD Richey Hospice 838 No E N. Entaw St Baltimore, MD 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 2 2004

Registrar's Signature

32.

		1	For State Registrative ND TIM #19	State of Marylar	nd / Depa	artment of h	lealth a	ind Mer		ene 200L	15116
			Decedent's Name (First, Middle, L.)	a Prk FH G832 b/U2	//U4_Jii				Date of Death		3. Time of Death
	Physicia /Medic		ELMER A	HICKS				W	AY 5	2009	
>	Examin	_	4a. Facility Name (If not institution, ga	ve street and number)		4b. City, Town, o		f Death		4c. County of Deat	h
			Bon Secours Ho 5. Social Security Number 6.	spital Sex 7. Age (In yrs.	last birthday)	Baltim If Under 1 Year		24 Hrs. 8.	Date of Birth	9. Birt	hplace (State or Foreign
	Funeral Director	İ		1⊠M 2□F 87	Yrs.	Months Days	Hours	Min.	(Month, Day, 1)	Year) Co	Md
			212-16-6949 Usual Residence of Decedent								10d. Inside City Limits
	show det	_	10a. State 10b. County		ity, Town or Lo Ba1to	cation					1 1 Yes 2 □ No
	he Ma	ecto	Md N  10e. Street and Number	/A	Dallo	10f. Zip Code			10	g. Citizen of What Co	puntry?
	with tage	급	1947 Ridgehill	Avenue			217			USA	
	within 72 hours after death with the Maryland ene. Itan "natural", or items 23a or 28a-f show he Medical Exama nor must be motified at	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of I	Hispanic Orig	gin? (Specify		14. Race - Ame Black, Whit	
9	or Ite	/ Fur	1 Never Married 2 ☐ Married	1 t√ Yes 2 ☐ No If <del>Y</del> es, Give		1 ☐ Yes 2 ☑ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 6.6.,	Specify:	Black
21215-0036	hours ural',	d b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16a Dece	dent's Usual Occu	nation		1	6b. Kind of Business	
7	in 72 n "nat	Completed	(Specify only highest of	rade completed)	(Give	kind of work done DO NOT use retire	during most ed)	t of working			-
212	d with giene. rr than	mo	Elementary/Secondary (0-12)  5th grade	College (1-4or 5+) N/A	Tru	ıck Drive					Unk
pu	be filed ital Hygid od other event, t	Be C	17. Father's Name (First, Middle, La.	st)						faiden Sumame)	
yla	should the marked umatic e	P	John Hicks	(Town a Orient)	10h Maili	na Addrona /Stroo			Buchan	City or Town, State,	Zin Code)
Maryland	d 2 sho		19a. Informant's Name/Relationship  James Coates,	Jr - Mother		•				Md 21216	,
di.	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the Marylan them 1970 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exam and in the motified at	1 4	20a. Method of Disposition	20b.		osition (Name of matory or other pla		Date		20c. Location - City or	Town, State
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1 Donation 5 Other (Spe	Hemoval from State		on Forest	1	5/12/	2004	Owings Mi	lls, Md
alti	permit. Departm Importa any inju		21. Signature of Fundial Service Lic	ensee	22	2. Name and Addr					
8	88 = 8		Syrette	1- Jones		430				Balt, Md	21215 Approximate
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each line.	04.040	ter the mode of dy	ing, such as	cardiac or re	espiratory arre	151,	Interval Between Onset and Death
-	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hynt L Due to (d as a conse	NS164						
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	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)				Month	Day Year
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Vital	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical				26. Place	e of Death (C	Check only on		
Ξ	Physician: rthis certific ral director,	To B	examiner? 1  Yes 2		☐ ER/Outpatie	nt 3L DOA				ence 6 □Other (Spe	ecify)
n of	ding Pt .r After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Pate of Injury (Month, Day Year)	28b. Time o Injury	W			d. Describe ho	w injury occurred	
sio	Attending ir death. ector: After by the fune	catl	2 Accident investiga	t be 290 Place of Injunt - At	home farm si		⊒Yes 2□	-		reet and Number or F	Rural Route Number,
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	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying	Physicien: To the best of my k keminer: On the basis of exami	nowledge, dea	th occurred at the	time, date ar	nd place, and	d due to the ca	ause(s) and manner a	s stated. e to the cause(s)
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	, X	1	30. Name and address of person w	ho completed cause of death (li	tem 23a) (Type	Print)	, , 0+0	رب م		1. Wy 3	2007
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1. Decedent's Name (First, Mic	ddle, Last)	-		Cer	tificate o	r Deatr	7	2. Date of D				3. Time	
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4a. Facility Name (If not institut					4b. City, Town	or Location	of Death		4		y of Death	1	
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5. Social Security Number	6. Sex		ge (In yrs. last i	birthday)	If Under 1 Ye		r 24 Hrs. Min.	8. Date of B	irth	r)	9. Birth	place (State untry)	or F
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MARYLAND  10e. Street and Number  3321 ST AMBI  11. Marital Status  1 Never Married 2 M					212					U.S			
11. Marital Status	Arr	med Forces		13. V	Vas Decedent of Yes, specify C	f Hispanic O Jban, Mexica	rigin? (Spe an, Puerto	ecify Yes or N Rican, etc.)	lo-		ce - Amer ack, White	ican Indian, , etc.	
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Registrar

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permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Items 23e or 28e-f show

Physic /Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

Granys JOHNSON

Baltimore, Maryland 21215-0036

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BALTIMORE

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			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of F	lealth and I Death	Mental Hy	giene Peg. No. 200	4 15118
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of De Month	Day Ye	3. Time of Death
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	Funeral		5. Social Security Number 6. Se.	x 7. Age (In vrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Birthplece (State or Foreign Country)
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	and and		Usuel Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Many -f ehc	tor	Maryland Anne Ar	undel	Jessu	0				1 ☐ Yes 2 No
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	23a c	raiD	2065 Montevideo R	oad		20794	1		United St	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show say injury or other traumatic event. The Medical Examinan main the multiplial at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3XXVidowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces?  1 Yes 22 No If Yes, Give	1	Was Decedent of H f Yes, specify Cuba l □ Yes 2 XNo	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Black, V	American Indian, Vhite, etc. White
8	ture!	ed b	15. Decedent's Edu	Year or Dates:	16a. Deced	lent's Usual Occup	ation		16b. Kind of Busin	ess/Industry
215	hin 72	piet	(Specify only highest grad Elementary/Secondary (0-12)	le completed)  College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	during most of wor d)	king		
21	ed wit	Completed	12	2	Gard	dener			Own Busi	ness
Maryland 21215-0036	ntal H	Be	17. Father's Name (First, Middle, Last) Franklin Heinrick			The state of the s		ne (First, Middle) ne Horva	, Maiden Sumame) att	
7	should ind Men marke umatic	ဥ	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailin	a Address (Street			er, City or Town, Sta	te, Zip Code)
	and 2 sauth ar n 27 le		Francis Jacobs -			Montevide			Maryland	
re,	of Head		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place		Date	20c. Location - City	
<u>=</u>	Pages ment of ant: If it ury or o	.,,	1 ☐ Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)		eadowric	dge Mem.	Pk. 5/1	3/04	Elkridge,	Maryland
Baltimore,	permit. Departr Importa eny inje		21. Signature of Funeral Service Licens  M. Pah	ee	Ge 7:	Name and Address ary L. Ka 250 Washi	ss of Facility aufman Fu ngton Bl	neral Ho vd. Elk	ome At MME kridge, Ma	P., Inc. cryland 21075
	£		23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused the dea ne cause on each line.						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			Y	TYPERT	ENSID	N	YEARS
100	/Medical Examiner		resulting in deality	Due to (or as a conse	,		115 010	1 1 1 1 1 2 1 1	way wer	ASE YEARS
	9.30	er	Sequentially list conditions, if any, leading to immediate	b. CHRONIC Due to (or as a conse	quence of):	TRUCIII	ve ru	LIVIUNA	P74 9 1136	-ASE / CA743
	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	С.						
Ö,	e exer ian ar urial-t	I Ex	resulting in death) Last	Due to (or as a conse-	quence of):					
8760,	cate be executed physician and the burial-transit	dical		d						
9 x	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy				23d. Date of	delivery
Box	death certifi e attending J ed for use as	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		]Ectopic pregnancy ] Other (specify)	'		Month	Day Year
Ö	that the death ed by the atte detached for	hys	9 Unknown	9□ Unknown						
S, P	Se Ge	by P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.		/	e to the cause of death?
Vital Records,	v requir been si should	Completed						1 🖫		Probably 4 Unknown
3ec	e law has b	mple						24a. Was autor		autopsy findings available to completion of cause of
alF		e Co	25. Was case referred to medical					1 ☐ Yes	2 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 No
	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatien	t 3 DOA Oth	er: 4 □ Nursing H		dence 6 Other (S	Specify)
J Of	ng Phys ter this neral di	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		y at		now injury occurred	,,,,,,
sio	Attanding r death. actor: Atter by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of	after d after d Diract d in by	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		eet, factory, office		28f. Location (S City or Tov		r Rural Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edicai C	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medicel Exemi	rsicien: To the best of my kn iner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the ting restigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	₹	29b. Signature and title of certifier	2 /2		29c. Licens			29d. Date signed (M	onth, Dey, Year)
)			1 Bund	ia no		D <	12892		MAY 11	, 2004
	W		30. Name and address of person who of	84.0-		the state of the s	A Company	<b>€</b> 00	01011	COLUMBIA MD 2104
		to.	31. Date filed (Month, Day, Year)	32. Registrar's Sign		ITLE P	ATUXEN	VI PA	MILLAY	1 MD 2104
	Sta Registi		MA'		FORME !	14 Ano	all 9			

ORIGINAL

	For		d / Department of Certificate of	Health and Mer	-	2001	15110
Obviolog	Registrar  1. Decedent's Name (First, Middle, Last)		Conmodito of	2.	Date of Death Month Da	y Year	3. Time of Death
Physician /Medical Examiner	THURMAN  4a. Facility Name (If not institution, give s	CALVIN street and number)		or Location of Death	40	2004 County of Death	6: 30 P <sup>M</sup>
Funeral Director	215-18-1594		HAGERS' last birthday) If Under 1 Yea Months Day	r If Under 24 Hrs. 8. s Hours Min.	Date of Birth (Month, Day, Yeer, cember 9,		N blace (State or Foreign ntry) ryland
death with the Maryland ms 23a or 28e-f show if mant by notified at merel Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Washi  10e. Street and Number		gerstown		10g. Ci	itizen of What Cou	10d. Inside City Limits 1√ Yes 2 □ No ntry?
5 2 M . 7	1183 Luther Dr	12. Was Decedent Ever in U. Armed Forces? 1 (2) Yes 2 □ No If Yes, Give Year or Dates: 1942	S. 13. Was Decedent o	7 4 0  Hispanic Origin? (Specifyliban, Mexican, Puerto Ric		U.S.A.  14. Race - Americ Black, White,  Specify: Wh	etc.
nd 21215-003 e filed within 72 hours al Hygiene. other than "naturel, vent, the Medical Exe	(Specify only highest grade	cation	16a. Decedent's Usual Occ	ne during most of working red)		Kind of Business/In	nufacture
Aaryland 2 2 should be filled 2 should be filled 4 and Mental Hygin 4 is marked other raumatic event, II To Be CC	17. Father's Name (First, Middle, Last) Vinton	J. Jor	ies	18. Mother's Name (F		Mar	
Ore, Nest and of Health If item 27	19a. Informant's Name/Relationship (Ty Bernice Ann Wolfens 20a. Method of Disposition 1X Burial 2 Cremation 3 F	sberger Daught	lace of Disposition (Name of emetery, crematory or other p	Rock Drive,	Hagersto 20c. L	OWN, Mary Location - City or To	land 21740 own, State
Baltimo permit. Pag Department important: eny injury o	4 □ Donation 5 □ Other (Specify)     21. Signature of Funeral Service Licens     Real Br	ady	est Haven Ceme 22. Name and Add Andrew K. 40 East A	dress of Facility  Coffman Fun  ntietam Stre	eral Home		Maryland
760, te be executed System and the burial-transit cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):				Interval Between Onset and Death 2 weeks
of Vital Records, P.O. Box 687 Physicien: The law requires that the death certificate this certificate has been signed by the attending phys ral director, page 2 should be detached for use as the ; To Be Completed by Physician/Medic.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 Ectopic pregna			23d. Date of deliv Month	ery Day Year
rds, P. rds, p. ruices that the signed by the detailed by Ph	Part II. Other significant conditions co cereb 10 vas cular	ntributing to death but not res	ulting in the underlying cause	given in Part I.	23e. Did tobacco		the cause of death?
Calvin  If Records  The law require  rate has been signage 2 should the	congestive head decubitus vice	rt Failure.			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	prior to co	opsy findings available ompletion of cause of
Dr effe	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending investigation	Hospital: 1 Inpatient 2 Inpatient 2 Month, Day Year)	28b. Time of Injury 28c. Ir	26. Place of Death (Conter: 4 Nursing Home light) Nursing Home vork?			(y)
JONES, Thui Division of Divisi	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory, offic ly)	28f	Location (Street a City or Town, State	and Number or Rur te)	al Route Number,
JONES, TP Division  To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the tumedical Certification.	29a. Certifier (Check only one)  1 ☑ Certifying Phy 2 ☐ Medical Exem		owledge, death occurred at the		at the time, date ar		o the cause(s)
with voin	Cynthia Ku	the Sand	no Di	17451	Ma	y 5, 20	04
State	30. Name and address of person who of Cynthia Kuttoer— 31. Date filed (Month, Day, Year)  MAY 1 2 2004	ompleted cause of death (Itel		Church K	oad, Ho	agerston J 217+	un, Marylan

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

		•	For State Ragistrar	State of Marylan	Cei	tificate of Death	h	Reg.	profe and all a	4 15120
	Physicia	17	1. Decedent's Name (First, Middle, Last)					. Date of Death Month	Day Yee	
	/Medic	ai		KSON		4b. City, Town, or Locatio		MAY 8,	2004 4c. County of De	11:00a M
10.	Examin	er	4a. Facility Name (If not institution, give s MARINER of CATO			Catonsvil			Balti	
	Funeral		5. Social Security Number 6. Sex				er 24 Hrs. 8.	Date of Birth (Month, Day, Ye	9. E	Birthplace (State or Foreign Country)
	Director		220-20-3157 18 Usuel Residence of Decedent	M 2□F 74	Yrs.			Jan.25,	1930	Maryland
	/land	}	10a. State 10b. County	10c. Cit	y. Town or Lo	cation				10d. Inside City Limits
	a-feh	ctor	M.D. N/A	Ва	ltimo	re				1 MYes 2 □ No
	vith the	Director	10e. Street and Number 2710 Ellicott D	misso		10f. Zip Code 21216		10g.	. Citizen of What U.S.A	
	ns 23e	Funeral		12. Was Decedent Ever in U	.S. 13. 1	Was Decedent of Hispanic ( f Yes, specify Cuban, Mexic	Origin? (Specif	ly Yes or No-	14. Race - A	merican Indian,
036	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other then "natural", or liems 23a or 28a-f ehow imatic event, the Medical Exam for must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 XYes 2 □ No 19 If Yes, Give Year or Dates: 194	147	f Yes, specify Cuban, Mexic 1 ☐ Yes 2½ No Speci		ćan, etc.)	Black, W	
Maryland 21215-0036	natur	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupation kind of work done during m DO NOT use retired)	ost of working	161	b. Kind of Busine	ss/Industry
212	1 withir piene. r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		dry Forema			ynn &	Emrich
nd	al Hygie d other	Bec	17. Father's Name (First, Middle, Last)	T- ale - on				First, Middle, Mai		
yla	should be tand Mental to marked or umatic eve	2	Alfred Francis  19a. Informant's Name/Relationship (Ty		10b Mailin	E I V		Briscoe		. Zin Codo)
N S	od 2 sl Ith an 27 is r r traur		Vivian L. Jacks			Ellicott				
Baltimore,	of Hea of Hea ritem		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ R	20b. F	Place of Dispo	sition (Name of matory or other place)	Date	e 20d	c. Location - City	or Town, State
Ĕ	Page tment tant: h		* 4 □ Donation 5 □ Other (Specify)	har		Forest	1			Mills, M.D.
Ba	permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If item 27 is marked ony injury or other traumatic or QRGs.		21. Signature of Funeral Service Licens	2 Nulle	25	2. Name and Address of Fac 01 Gwynnsf	alls E	Pkwy,Ba	lto.,M	.D. 21216
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat re cause on each line.	h. Do not ent	er the mode of dying, such	as cardiac or r	espiratory arrest,	,	Approximate Interval Between Onset and Death
Kij *	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Broncho-pnet  Due to (or as a consequence)						One Week.
120	Examiner		Commentation that are different	Multiple Mye						Years.
	sit ad	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	juence of):					
	xecute n and al-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	juence of);					
68760,	ificate be executed g physician and as the burial-transit	edical E	L,	l. ==						
			IF FEMALE:	On If you automore of manner						
). Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	by Physiclan/M	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
P.O.	that the ad by t detach	Phy	9 Unknown  Part II, Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause given in Pa	rt I.	23e. Did tobac	co use contribute	to the cause of death?
ds,	uires l n signe	d by	Cervical Disc Dis	•	-			1 🗆 Yes	2 <b>⊠</b> No 3□	Probably 4 Unknown
000	aw require 1s been si 2 should b	Completed	Quadruparesis.					24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
Ä	The tate has page	Com						performed	d? death	
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	lospital:		0.1		Check only one)		
o	Phys or this oral dir	. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	IL SU DOA   442		5 Residence d. Describe how	e 6 Other (S	pecify)
ion	ath. r: Afte	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 Yes 2	□No			
Division of Vital Records,	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, larm, st fy)	eet, lactory, office	28	f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sicien: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the time, date vestigation, in my opinion, c	and place, and death occurred	d due to the caus at the time, date	se(s) and manner and place, and c	as stated. lue to the cause(s)
	To the k within 24 To the F complete	Me	29b. Signature and title of certifier	Doad! -	_	29c. License numbe		29d.	. Date signed (Mo	onth, Day, Year)
•	/		10 18. 10			D 30469	9.	May	7 11,	2004.
	'n		30. Name and address of person who con N . B Vellanki, MD;	mpleted cause of death (Iter 9055 Chevrole	n 23a) (Type, et Driv	Print) Je, #100. Ell	icott (	Citv.MD	21042	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature			CI CY PUID	41034.	
	Regist	ar	MAY 1 2 2	1004 Daner	The state of	sports	_			

•		1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H		-	200	1. 15101
		Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
Physici /Medic		MILI	NDA HOPI	E JORDAN			Month APR	Day Yee:	6:36 A M
Examin	er	4a. Fecility Name (If not institution, give s			4b. City, Town, or			4c. County of De	
-		NATIONAL NAVA  5. Social Security Number 6. Sex		J CENTER ge (In yrs. last birthday)	BE If Under 1 Year	THESDA	-		rgomery
Funeral Director			M 2000	yrs. Yrs.	Months Days		Min. 8. Date of Birt (Month, De April 1	y, Year) (	irthplece (State or Foreign Country) aryland
pu ,		Usuel Residence of Decedent					APITI	4, 2004 P	
anyian •how	7	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
the M 28e-f	Director	Maryland Montgo  10e. Street and Number	mery	Bethesda	10f. Zip Code				1 ☐ Yes 2 No
with 3a or		8901 Wisconsin Ave	I_		20814			10g. Citizen of What (	country?
death ms 2:	Funeral		12. Was Decedent	Ever in U.S. 13.		spanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am	
after or Its	Ē	1 X Never Married 2 ☐ Married	Armed Forces* 1 ☐ Yes 2 [X] If Yes, Give	No	_ **	n, Mexican, F Specify:	Puerto Rican, etc.)		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher than "naturel", or Itams 23a or 28e-1 show int, the Medical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: Wh	
in 72 in 72 in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired	urina most o	of working	16b. Kind of Busines	s/Industry
212 d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	N/A			N/A	
be file to othe event,	Be C	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·		18. Mother's	Name (First, Middle.	Maiden Sumame)	
aryla should to and Ment markace umatic	10	Eric M. Jordan					n O'Berst		
0 0 0		19a. Informant's Name/Relationship (Type Eric M. Jordan /	. ,				or Rural Route Numbe		Zip Code)
is 1 and 3 tem 27 item 27 other tre		20a. Method of Disposition	Tacher	20b. Place of Dispo	sition (Name of		, Bethesda	, MD 20814 20c. Location - City o	Tour State
Itimore, it. Peges 1 ar rriment of Hea rdant: If Item:		1 X Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crem	natory or other place	1	/27/04	Springvil	
Baltimore permit. Peges 1 Department of H important: If ite any injury or ott		21. Signature of Funeral Service License	9	22	Name and Address	s of Facility			ie, Ni
0 8858		Jennis (i	ulmo	en 2	mith-Weis 71 E. Mai	mantle n St.	e Funeral   , Springvi	Home 11e. NY 14	141
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused e cause on each li	d the death. Do not enti-	er the mode of dying	, such as ca	rdiac or respiratory arr	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)		PULMONARY	HEMORRHA	AGE			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
- A	er	Sequentially list conditions, if any, leading to immediate	Due to (or as	EXTREME I	PREMATURI	<u>ry</u>			
cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
		resulting in death) Last	Due to (or as	a consequence of):					
18 760, cate be executed physician and ithe burial-transit	dical	d.							
Box 6 leath certific attending p	lan/Me	IF FEMALE:	lc. If yes, outcome	of pregnancy					
	clan	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
that the de detached detached	hysic	1 □ Yes ② No 9 □ Unknown	9□ Unknown						
ords, P.O requires that the neen signed by th		Part II. Other significant conditions cont	ributing to death b	ut not resulting in the un	derlying cause giver	n in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
w require been signature should b							1Ye	es 2.∭Mo 3.∏.P	robably 4 DUnknown
as b	ompleted	-					24a. Was a autops	n 24b. Were at	utopsy findings available completion of cause of
_ F # d	O L						perform Yas 2	ned? death? 2 No 1 Yes	
	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 [X]No  Ho	ospital:		Other		Death (Check only on	-/	
g Physe er this ieral di	-	27. Manner of Death	1 N Inpatie	ry 28b. Time of	28c. Injury a	# [] Nursir	ng Home 5 Reside	ince 6 □Other <i>(Spe</i> iw inju <b>ry</b> occurred	cify)
Attending r death. ector: After by the fune	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	y Ye <i>er)</i> Injury	Work?	es 2 □ No			
INISION I or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-	ury - At home, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number or Ri	ural Route Number,
pitei o		00-0-4					1	,	
UIVISION O To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine	cian: To the best of er: Onythe basis of and manner sta	of my knowledge, death examination and/or inv ated.	occurred at the time estigation, in my opin	, date and pl nion, death o	lace, and due to the ca occurred at the time, da	iuse(s) and manner as ite and place, and due	stated. to the cause(s)
ro the vithin ro the complex		29b. Signature and title of certifier		itod.	29c. License i			d. Date signed (Monti	
. > - 0		1/ / LOI	M		01051	105A (		04/21	104
		30. Name and address of person who com	neted cause of d	eath (Item 23a) (Type, F			NAVAL MED	CAL CENTER	
				JSA	BET	HESDA	MD 20889-5	600	
Stat Registra		31. Date filed (Month, Day, Year)		ar's Signature	Souls				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 0 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 ALICG JOYNER 10.00 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town or Location of Death Examiner Baltimore Baltimore Hospit 8. Date of Birth (Month, Day, Year) Cont. 14, 1946 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F 57 241-82-3029 Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits ?7 is markad other than "natural", or itams 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at 1 TxYes 2 □ No Director M.D. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5500 W. North Avenue 21207 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deat Depirtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any njury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 257 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th House Wife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jesse McPherson McPherson Clora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sabrina Joyner- Daughter 5500 W. North Avenue, Balto., M.D. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/11/2004 Balto., M.D. Metro Crematory \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Home Inc. 21. Signature of Funeral Service Licensee 2501 Gwynnsfalls Pkwy, Balto., M.D. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mus cardial Pnysician LOUGE /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner use as the burial-transit requires that the death certificate be executed attending physician and Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year for Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 eyce malo rally Digletic 1 Yes 2 No 3 Probably 4 Unknown certificate hes been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Wasan 1 Yes 2 No Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending death. investigation 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed seuse of death (Item 23a) (Type, Print) Rangenajav

Registrar DHMH 17 Rev 1/2001

State

Kamaswany

MAY 1 2 2004

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 540pm IACKSON 10pa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mercy Hospital - Hospice Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F 213-28-3589 71 Nov.30,1932 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-4 show other traumatic event, the Medical Examinar must be notified at Yes 2 No Funeral Director N/A M.D. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 Argonne Drive 21218 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Syes 2 No 1952 If Yes, Give Year or Dates: 1956 72 hours after 1√2 Never Married 2 ☐ Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Western Electric 2years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be and Mental Theodore Jackson Emma Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nellie Jackson - Sister 2109 Fernglen Way, Catonsville, M.D. 21228 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages per it. Pages Department of Important: if it 1 Surial 2 Cremation 3 Removal from State Druid Ridge Cem. 5/17/2004 Pikesville, M.D. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Home Inc. 21. Signature of Funeral Service Licensee 2501 Gwynnstalls Pkwy, Balto., M.D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it is to be a light conditions, it is to be a light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of Physician/Medical Examiner The law requires that the death certificate be executed inding physicien and use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atter 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1□ Yes 2☑No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ပ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 40854 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) By 14mm 21202 Risebers 301 Place 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 2 2004

DHMH 17 Rev 1/2001

JAC KSON

		1 - For State Registrar	State of Maryla		artment of rtificate o		nd Mental Hy	gien Reg. No	2001.	15121
		Decedent's Name (First, Middle, Last	)				2. Date of D	eath		3. Time of Death
Physic /Med		Ruth K. Johnson					May 10	), 2(	)04 Year	5:15 A M
Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of			. County of Death	
		Washington Adventi			Takoma				ntgomery	•
Funera Directo		5. Social Security Number 6. Se 15	x 7. Age ( <i>In yr</i> s □ M 2ᡚ F 79	. last birthday) Yrs.	If Under 1 Year Months Day		Min. 8. Date of B (Month, D April 2	rth a <i>y, Year</i> O 10	9. Birth	place (State or Foreign ntry)
		Usual Residence of Decedent					тріті 2	0, 1	925  Mary	Land
ryland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
e Ma	Director	Maryland Montgomer	y Sil	lver Sp	ring					1 □Yes 21☑No
ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Cou	ntry?
s 23s	ral	203 Williamsburg D			2090				ted Stat	
item item	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of If Yes, specify Co	f Hispanic Origir uban, Mexican, f	n? (Specify Yes or N Puerto Rican, etc.)	0-	<ol> <li>Race - Americ Black, White,</li> </ol>	
re, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Evantinal must be notified at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2√∑N	lo Specify:			Specify: Whi	te
21215-0036 d within 72 hours at glene. er than "natural", or , the Medical Every	ted	15. Decedent's Edu	cation		dent's Usual Occ			16b. K	(ind of Business/In	
215 Thin 7	Completed	(Specify only highest grad	(e completed)  College (1-4or 5+)	(Give life.	kind of work don DO NOT use reti	ne during most o ired)	f working			
d 21, filed wit Hygien ent, the	NO.	12	-	Sec	retary			Doc	tor's Of	fice
Maryland 212 d 2 should be filed withi th and Mental Hygiene. I? Is marked other ther traumatic event, the M	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maider	Sumame)	
Van Ould Wen	T <sub>o</sub>	Roy B. Johnson					K. Sapp		,	
Marylan 12 should be n and Mental 18 marked or		19a. Informant's Name/Relationship (Ty					or Rural Route Numb			
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 27 i my injury or other tre		David R. Campbell/ 20a. Method of Disposition			NILLIAMS esition (Name of		ive, Silv			
Baltimore,  bermit. Pages 1 at Department of Hea mportsnt: If item ing injury or othe		1 ☐ Burial 2 反 Cremation 3 ☐ F	Removal from State	Monte	natory or other p omerv	lace)			ocation - City or To ethesda,	
Iting it. Part rtmer rtsnt njury		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funer J Service Voe 3	A   Cr	emator	ium, Inc	Tra.	y 12, 2004	D	Maryland	d neral Home
Baltimor permit. Pages : Department of the important: if ite any injury or of		*XKAn/) H	100689	R	ockville	Inc.	300 West ryland 20	Mont	gomery A	venue,
Physician		23a Part . The disease, or complete the diseas	ications that caused the dea	/	er the mode of d	ying, such as ca	rdiac or respiratory a	ırrest,	2803	Approximate Interval Between Onset and Death
/Medica	_	disease or condition resulting in death)	a. Due to (or as a conte		rary	11/1	ST			
Examine			Conset	ke He	ent Fa	ilvre				
	Je.	if any, leading to immediate	Due to (or as a conse				A .			
cuted	Examiner	Cause (Disease or injury that initiated events	. Atherosc	lerot	is Cor	onary	Arter	Di	serge	
e exe	EX	resulting in death) Last	Due to (or as a conse	quence of):			3/1			
8 / 6U, cate be executed ohysician and the burial-transit	dical		d							
Hecords, P.O. Box 68/60,  The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	a	IF FEMALE:	20. 14							
BOX 6 eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 mgaths?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3 □	Ectopic pregnan	псу			23d. Date of delive Month	ery Day Year
by the a	yslc	1 ☐ Yes 2 █No 9 ☐ Unknown	4□Pregnant at time of a 9□Unknown	death 5∟	Other (specify)					
that the ed by		Part II. Other significant conditions cor	ntributing to death but not re-	sulting in the u	nderlying cause o	aven in Part I.	23e. Did	obacco i	use contribute to th	ne cause of death?
dS, uires i sign id be	d by				, ,	,		Yes 2		ably 4 Minknown
VITAI KECOTGS, sician: The law requires t certificate has been signe rector, page 2 should be o	lete						240 1400		045 14(222 2.14	
The lay	Completed						24a. Was auto		prior to cor death?	psy findings available apletion of cause of
	ပိ	25. Was case referred to medical				00.01	1 ☐ Yes	2 No		2 No
	o B	examiner?	Hospital: 1. Inpatient 2	] ER/Outpatien	t 3□ DOA O	No.	Death (Check only only only only only only only only		0.5504 (0.4	
Phy a Phy er this	1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe			/)
ISION (trending death.	atlo	1 ☐fÑatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ⊒Yes 2 ⊒No				
LIVISION  I or Attending after death.  Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, office	8	28f. Location ( City or To	Street an	d Number or Rura	l Route Number,
Saft Blog	Cer		building, old. (opad)				Chy of 10	wii, State	/	
To the Hospital or Attervision 24 hours after de To the Funeral Directorompletely filled in by the	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my known of the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at the restigation, in my	time, date and p	lace, and due to the occurred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of pertifier	and manner stated.		29c. Licer	nse number		29d. Dat	e signed (Month, I	Day Year)
► 3 F ŏ		1				7649			11012	
$\wedge$		30. Name and address of person who co	ompleted cause of death (Ites	m 23a) (Type		16-11			11012	804
. /		Bryan M. Steinber			•	NW. #24	OON Wash-	ino+	an DC 20	010-2094
⊮ ∍ S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature			wasii.	rnRr(	<i>μ</i>	1010-2900
Regis		MAY 1 2 2004	Genera	19	land 1	,				

		•	1 - For State Registrar	State of	f Maryland / D		nent of H		and Mental Hy	ygiene Reg. No. 2	004	15125
	Physicia	an	1. Decedent's Name (First, Mide	OHNSON					2. Date of D Month May 6,	Day	Year	3. Time of Death 5:30pm M
	/Medic Examin		4a. Facility Name (If not instituti		nber)	4b.	City, Town, or	Location o		-	nty of Death	3.30pm
	Examin		Lorien Nursing	-		В	altimor	re			N/A	
	Funeral		5. Social Security Number		7. Age (In yrs. last birt	MAG	Inder 1 Year nths Days	If Under a	24 Hrs. 8. Date of B Min. /Month_D	irth 194, Year) 4, 1927	9. Birth	place (State or Foreign
	Director		225 16 8401 Usual Residence of Decedent	1 <b>X</b> M 2UF	80	Yrs.			DUNE T	4, 1927	VA	
	land ow		10a. State 10b. Count	ty	10c. City, Town	n or Locatio	n					0d. Inside City Limits
	Mary I sh	ğ	MD N	14	BALTIMO	RE						1 Å Yes 2 □ No
	or 282	irec	10e. Street and Number	.017			of. Zip Code			10g. Citizen	of What Cou	ntry?
	ath wi	rai	1931 N. PATTERS				1213			U.S.A		
396	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, Ite Modical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Fo	<sup>2</sup> □42 <u>-16-46</u> 3	13. Was I If Yes	Decedent of His, specify Cubar of the specify Cubar	spanic Orion, Mexican Specify:	gin? (Specify Yes or N I, Puerto Rican, etc.)		lace - Americ Black, White, cify: BL2	etc.
9	72 hou	ted	15. Decede	ent's Education lest grade completed)	16a.	Decedent's	Usual Occupa	ition	t of working		Business/In	
21215-0036	within 7 ene. than *r	Completed	Elementary/Secondary (0-12)				of work done d OT use retired,	)	or working	BALTIM SANITA		
	e filed within al Hygiene. I other than vent, I come		10th 17. Father's Name (First, Middle	a / act)	LAB	ORER		18 Mothe	er's Name (First, Middl			THE I
Maryland	2 should be fi and Mental F Is marked ot reumatic ever	To Be	UNKNOWN	5, Lasi/				UNKNO	OWN			
	and 2 sho ealth and n 27 is m		19a, Informant's Name/Relation					38 SI	r or Rural Route Num Γ. LOUIS, Ν	1D 6310	1	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other ance.		20a. Method of Disposition			y, cremator	(Name of y or other place REST OW		4AY 13, 200 MILLS,	4 <sup>20c. Location</sup> MARYLAI		own, State
Balti	permit. Pages. Department of I Importent: If Ite any injury or of once.		Ignature of Funeral Service	e Licensee	auga -	22. Nar	me and Addres	s of Facilit	CALVIN B.	SCRUG	GS FUN	ERAL HOME
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that c st only one causn e	aused the death. Do r	not enter the	mode of dying	g, such as	cardiac or respiratory	arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	A	SVCD						- 1	Onset and Death
	/Medical Examiner		resulting in death)	Due to	or as a consequence							
	Lamine	<u>.</u>	Sequentially list conditions,	b. Due to	Or as a consequence							
	ted nsit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying cause. Underlying										
,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (	or as a consequence	of):						
8760,	ate be nysicia he buri			d								
9	rtificat ng phy as th	ledi	IF FEMALE:				_					
Box (	law requires that the death centificate be executed as been signed by the attending physician and . Should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live b	come of pregnancy irth 2 Fetal death ant at time of death		pic pregnancy er (specify)				Date of delive Month	ery Day Year
P.0	that the d ed by the detached	Phy	9 Unknown			the under	vina coulan anua	n in Bart I	23a Did	tobacco usa co	antribute to t	ne cause of death?
rds,	w requires that been signed should be de	by	Part II. Other significant condi	tions contributing to de	satir but not resulting if	r tile under	ying cause give	minirani.		Yes 2□No		
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Vital	riclen: Th certificate rector, pag	O	25. Was case referred to medic	cal				26. Place	of Death (Check only		163	2000
of V	S S	To B	examiner? 1 Tyes 2 No	Hospital: 1 🗆 l	npatient 2 ER/Ou	tpatient 3	DOA Othe	PIT NEW	rsing Home 5 Res	sidence 6 🗆 0	Other (Specif	y)
			27. Manner of Death  Natural 5 Pend	28a. Date		Time of njury	28c. Injury Work			how injury occ	urred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident inves	stigation d not be	- 6 laine - AA baara 6-	N		/es 2 □!		(Ctroat and No.	mharar Own	J Courte Mumber
Division	ospitel or At hours after ouneral Direct uneral Directly filled in by	Certification:	4 Homicide dete	mined 288. Place buildi	of Injury - At home, fa ng, etc. (Specily)	rm, street, r	астогу, опісе			own, State)	mber or Aura	d Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai		ring Physician: To the al Examiner: On the ba and man								
	To the H within 24 To the Fe	M	29b. Signature and title of certif	ier			29c. License			29d. Date sig		
	1		MMIME				D57	727	-	2/11	104	
_	BX.		30. Name and address of person	n who completed caus	V, 201-	(Туре, Print) - 109	Back	Liv	re Nech	Load	MD.	21221
	Sta Registi		31. Date filed (Month, Day, Yea		egistra s Signature	hour	e e					

			For State Registrar	State of Maryla		artment of Hortificate of L			ene 200	14 15126			
	Physicia	an	1. Decedent's Name (First, Middle, Last)  MARIE O. JONES-	BRYANT				2. Date of Death Month	Day Ye				
	/Medic Examin		4a. Facility Name (If not institution, give st Saint Joseph M		nter	4b. City, Town, or	Location of Death	Π	4c. County of D	Death 1 t i m o r e			
	Funeral Director		231-60-8178	7. Age ( <i>in</i> )	vrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6-7-19		Birthplace (State or Foreign Country) IRGINIA			
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or Lo	cation				10d. Inside City Limits			
	Many ined	to	MD. N/A		BALTIMO	RE				1 □XYes 2 □ No			
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	t Country?			
	s 23a		1120 POPLAR GROVE	ST.	- II C 12	21216 Was Decedent of Hi	anania Origin? /Cn	acifu Vac or No-	USA 14 Bace - A	American Indian,			
39	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Exactinating the notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, V	White, etc. BLACK			
2-0	72 hou	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done of	furing most of work.	ing 1	6b. Kind of Busin	ess/Industry			
21215-0036	er then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired, ETARY			CORRE	CTION			
Maryland	be filed ntal Hygie od other event, II	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		laiden Sumame)				
IZ S	2 should be f and Mental I is marked of reumatic eve	스	SOLOMON LEWIS  19a. Informant's Name/Relationship (Type	ne, Print)	19b. Maili	ng Address (Street a		BOOTHE  al Route Number,	City or Town, Sta	te, Zip Code)			
	l and 2 : Health ar Im 27 is her treu		ROSCOE BRYANT (HU	SBAND)	112	0 POPLAR	GROVE ST	. BALTIM	ORE, MAR	YLAND 21216			
Baltimore,	m ∩ ⊾		20a. Method of Disposition 1 以Burial 2 又 Cremation 3 以Re		b. Place of Dispo cemetery, crei	sition (Name of matory or other place	e) 5-1	5-2004 <sup>2</sup>	0c. Location - City	or Town, State			
tim	permit. Pages Department of I Importent: If It any injury or o		' 4 ☐Donation 5 ☐ Other (Specify)	M		TIAN BAPT				W, VIRGINIA			
Bal	Depariming on its process.		21. Sign of Funeral Service Libense	DONATHAN D						ME, P.A. RYLAND 21217			
			23a. Part. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the ce cause on each line.						Approximate Interval Between			
	Pnysician		Immediate Cause (Final disease or condition SEFSIS										
1	/Medical Examiner		resulting in death)	Due to (or as a con		FAILUR	) <u>F</u>						
		er	Sequentially list conditions, it is any leading to immediate cause. Enter Underlying	Due to (or as a cor		2 1 1 dt have tad 1 1	i- Reeva						
	ocuted nd transit	Examine	that initiated events										
60,	sician and burial-transit		resulting in death) Last	Due to (or as a cor	isequence of):								
09289	ficate g bhysi	edical	d										
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and yage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pro 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year			
rds, P.	quires that n signed b	by	Part II. Other significant conditions con	tributing to death but not	t resulting in the u	inderlying cause give	en in Part I.			te to the cause of death?  Probably 4 Dunknown			
Vital Record	The law require ate has been si page 2 should t	Completed						24a. Was an autopsy perform	/ prior				
/ita	sicien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	ospital:	-	Oth		h (Check only one	9)				
of \	Phys this al dii	-: To	1 ☐ Yes 2 No	1 inpatient	2 ER/Outpatie	The second secon	4   Italianing no	me 5 Resider	nce 6 Other ( w injury occurred	Specify)			
	Attending or death.	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury	Work	k? Yes 2 □ No						
Division	or Attendia after death. Director: A: I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, st	reet, factory, office		28f. Location (Str City or Town		r Rural Route Number,			
_	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C		sicien: To the best of my ner: On the basis of exal and manner stated.									
	To the within To the somple	Med	29b. Signature and title of certifies	1.		29c. License	e number	29	d. Date signed (N	donth, Day, Year)			
	.1		Dadingu & l	nella m.	D	D 41	.412	100	Jay og!	7, 2004.			
	P		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print)							
	C.	ate	JOGINDER F. MEL- 31. Date filed (Month, Day, Year)	32/Registrar's S	76 (7) 1 Signature	USLER DE	RIVE, TO	WSON, A	MARYLAN	D 21204			
	St Regist		MAY 1 2 2004	32/Registrar's S	JE AN	sule							

		•	1 - For State Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death	fental Hygier Reg. I	101
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	Physici /Medic		Roger Jam	es		April 26.	2004 0850 A. M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		4c. County of Death
			2816 E. Monument S	Street	Baltimore		N/A
	Funeral		5. Social Security Number 6. Sex	6 00 F	If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		121-40-761/	55 Yrs.		August 30	
	pue ≱_		Usual Residence of Decedent  10a. State 10b, County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Aaryl f sho	৳	MD N/A	Baltin	n 0 1 = 0		1 PYes 2 □ No
	28e-	Director	10e. Street and Number	54,777	10f, Zip Code	10g. (	Citizen of What Country?
	with the same		2816 E. Monu	and chant	21205		1254
	ns 23	Funerai			Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - American Indian,
10	fter d	ᇤ	1 Never Married 2 Married	1 Yes 2 Voo	If Yes, specify Cuban, Mexican, Puerto	Rićan, etc.)	Black, White, etc.
93	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
21215-0036	o 72 hours after death with the Maryland "neturel", or Items 23a or 28e-1 show can be neither at the continuence.	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Industry
2	c - 2	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	1	
		Son	1249		ecurity Guar	-0	Abacus Corp.
p	be filed tal Hyg d othe event,	Be (	17. Father's Name (First, Middle, Last)	_	/18. Mother's Name	e (First, Middle, Maid	en Sumame)
<u>   </u>		2	Cleveland	James	K	ose A	vers
Maryland	and and sm		19a. Informant's Name/Relationship (Ty)	11 0-	ng Address (Street and Number or Run		y or Town, State, Zip Code)
	1 and 2 Health em 27 l			es/daughter 45-	13 Northern Blu		0 FST NY 11369
ore	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		natory or other place)		Location - City or Town, State
Ē	Pages ment of I ent: If its ury or o		' 4 ☐ Donation 5 ☐ Other (Specify)	Bayvie	w Crematory May	10,2004	Baltimone, MD
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Incense	22	Name and Address of Facility	Funeral	Baltimone MD Service, P.A. Stimore MD 21201
ш	40 E 2 9				709 Tessier s	theet, Ba	16512 am aromith
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	DIABETIC KETO	AUDOSIS		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b				
	sit ad	iner	r any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	.  Due to (or as a consequence of):			
60,	icate be executed physician and s the burial-transit		,	Due to (or as a consequence or).			
68760,	cate b	dical	d				
		/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			
Вох	ath cattering	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 □	Ectopic pregnancy		23d. Date of delivery  Month Day Year
o.	it the de by the a tached t	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5☐ 9☐Unknown	Other (specify)		·
Δ.	that the ed by detac		Part II Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I	23e. Did tobacci	use contribute to the cause of death?
Records,	as as	1 by			,	1 ☐ Yes	_
Ö	w require been si should t	Completed				-	
3ec	elaw has l	mpi				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u>E</u>		Ö				1≱Yes 2□1	
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:	Other	(Check only one)	
of	Phys this	2	1 X Yes 2 No '' 27. Manner of Death	I Inpatient 2 ENOutpatien	it 3 DOA 4 Nursing Ho	me 5X Residence 28d. Describe how in	6 ☐Other (Specify)
L		io	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe now in	lary occurred
isi	uttendi death. ctor: A y the fu	ical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, str		28f. Location (Street	and Number or Rural Route Number,
Division	after death after death Director: ,	Certification:	4 Homicide determined	building, etc. (Specify)	cot, factory, office	City or Town, Sta	
_	spital ours serel filled		29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my knowledge, deat	occurred at the time, date and place	and due to the cause	(s) and manner as stated
	e Hospital or , 24 hours after e Funerel Dire letely filled in b	Medical	(Check only 2X Medical Examir one)	er: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date a	nd place, and due to the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	- s - ō		OF LAND	P	O.C.M.E.	Apr	ril 27, 2004
	7		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	Print)		
			-ANA RUBI		111 Penn Stree	t, Baltimo	ore, Maryland 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	/		
	Registi		MAY 1 2 2004	Server &	Spark		

Rodney	Johnson	n								
	04-161		Pleas			ndelible Ink. Ensure	-	_	ible.	
04-3	085		For State		-	partment of Health an		20	ΩI	15100
DAP		-	1 - State Registrar AMEND ITEM : 1. Decedent's Name (First, Middle,		31 5/18/04~6	Harificate of Death	2. Date of Dea	leg. No 🛴 🔱	<u>U4</u>	3. Time of Death
	Physicia		Rodney	1	on		Month	Day 6, 2004	Year	11:00p M
	/Medic Examin		4a. Facility Name (If not institution,		20-11	4b. City, Town, or Location of D		4c. County		11.000
			JOHNS HOPKINS HO			BALTIMORE CIT		N	/A	
	Funeral Director		5. Social Security Number 217-23-2656  Usual Residence of Decedent	5. Sex 1 M 2 □ F 7. Age	(In yrs. last birthda Yrs.	// If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth Min. Sept. 20	),1986	9. Birthp	olace (State or Foreign http) ryland
	aryland	۰.	10a, State 10b. County	Λ	10c. City, Town or	Location			1	0d. Inside City Limits 1   Yes 2 □ No
	he Ma 28a-f	ecto	Maryland N	H	Bal-	imore.		IO- Cities1	M/h - 1 O	
	be filed within 72 hours after death with the Maryland stal Hygiene.  do other than "naturel", or Items 23e or 28e-f ehow event, the Medical Eracil at must be rediffed at	<b>Funeral Director</b>	3711 N. Ro	paers t	Ave.	10f. Zip Code 2/207		log. Citizen of	SF	7
	tems :	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13	. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		ce - Americ ck, White,	
036	ours after	by	1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 ☐ Yes 2 XN If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 No Specify:		Specif	Bla	ack
15-0	72 ho	eted	15. Decedent's (Specify only highest		16a. Dec (Gir	edent's Usual Occupation re kind of work done during most of DO NOT use retired)	working	16b. Kind of B	usiness/Inc	dustry
21215-0036	l within jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	tudent		Hig	h 5	school
	be filed stal Hygi od other event, t	3e C	17. Father's Name (First, Middle, La	ist)	4	1 - 1 - 1	Name (First, Middle,	Maiden Surpan	пе)	100
Maryland	2 should be f and Mental h Is marked of reumatic eve	To Be	Rodney.	Johnson	n Sr.	Dor	othy IV	lae 1	lene	24
Mar	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		19a. Informant's Name/ elationship	(Type, Print)	unt) 19b. Ma	ling Address (Street and Number of	field A	City or Town.	State, Zip	M/21212
	as 1 and 3 of Health item 27 r other tr		20a. Method of Disposition	Carring	20b. Place of Dis	position (Name of ematory or other place)	/14/14	20c. Location	City or To	1.10
E O	Pages nent of I int: If its iry or o		1 ☐ Burial 2 SCremation 3 14 ☐ Donation 5 ☐ Other (Spe		Green	Mount Crematory	113/2004	Bal	to.	Md.
Baltimore,	permit. Page Department of Importent: If any injury or once.		21, Sign sure of Funeral Service Li	cense (		22. Name and Address of Facility	ce Fine	enal t	tome	
	205 29	1	Joseph	J' PL	100/19	ZZZ W. North	Ave. B	21.70. N	12.2	1216
			23a. Part . Enter the disease, or co shook, or heart falure. List or Immediate Cause (Final	in one cause on each lin	the death. Do not e		17551 071			Approximate Interval Between Onset and Death
	Pnysician . /Medical		disease or condition resulting in death)	a. Gunsho	a consequence of):	of right arm	and the	51	-	
1/8	Examiner				a consequence or;					
KN	d ii	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Que to (or as t	a consequence of):					
	and -transit	xaminer	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as:	consequence of):					
,60,	tificate be exig physician as the burial	ai Ex		, Dub to (or as t	a consequence of):					
687	tificate ig phys as the	edic		d						
P.O. Box 68760,	eath cer attendir for use	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the little of the l	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			te of delive anth	Day Year
	es that the d gned by the be detached	y Ph	Part II. Other significant condition	s contributing to death bu	ut not resulting in the	underlying cause given in Part I.	23e. Did tol	pacco use cont	ribute to th	e cause of death?
Records,	w requires been sign should be						1 Ye	es 2 No	3 Prob	ably 4 Dunknown
C S	a taw r nas be	Completed					24a. Was a autops	y	prior to con	psy findings available inpletion of cause of
	ician: The certificate ha							2□ No	death? Yes	2□ No
Vital	ysician: nis certific director,	o Be	25. Was case referred to medical examiner? 1 XYes 2 No	Hospital:	nt 2X ER/Outpati	Othor	Death (Check only on ng Home 5 Reside		or (Chasile	4)
of	ding Phys h. After this funeral di	n; To	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injury at	28d. Describe ho			7
ion	ttending I death. stor: After	atio	1 □ Natural 5 □ Pending 2 □ Accident investiga	tion May 6,20	- A	TO I TO Ven a Notice	Subject	was st	not	
Division	after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		iry - At home, farm, s (Specify)	treet, factory, office	28f. Los tion (St City of Town	reet and Numb	er or Rura	Route Number,
	spital or ours afte neral Dir filled in	i Ce	29a. Certifier 1 ☐ Certifying	Physician: To the hest of	road	ath occurred at the time, date and p				an mand
	To the Hospital within 24 hours a Youth to the Funeral Completely filled	edical	(Check only 2 Medical Exone)	ceminer: On the basis of and manner sta	examination and/or	investigation, in my opinion, death of	occurred at the time, d	ate and place.	and due to	the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifies	) / /		29c. License number		9d. Date signe		
			Jaska	JOO A	hes	OCME		4AY 7	,2004	:
	2		30 Hame and address of person w	completed cause of de	aath (Item 23a) (Type	e, Print) 11 <b>Penn Street,</b> 1	Baltimore	Marszla	იქ 21	201
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature			- ***** 10	<u>2</u> ]	で介工
	Registr	ar	MAY 1 2 2004	Beaute	D Ag	rach				

			1 - For State Registrar	State o	f Marylan	d / Depa <i>Cer</i>	artment of <i>tificate o</i>	Health a f Death	and M	ental F	Hygie Reg.	0 S <sub>ov</sub>	04	15129
	Physici /Medic		1. Decedent's Name (First, Middle, L Harry A. Kraf	•						2. Date of Month May		2004	Year	3. Time of Death 12:30 PMM
	Examir		4a. Facility Name (If not institution, gi Pickersgill Ret				4b. City, Town		of Death			4c. County Balt	of Death	2
	Funeral Director		217-10-9685	Sex 1∭ M 2□F	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of (Month, Apr	Birth Day, Ye	9ar) 1914	9. Birthp Coun Mary	
	e Maryland ta-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimo	re	10c. City	y, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with th	al Director	10e. Street and Number 615 Chestnut Ave	nue			10f. Zip Code	1204			10g.	Citizen of V US		try?
020	urs after dee al', or Itema	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 (Ž) No ve	l:	Vas Decedent of Yes, specify C	uban, Mexican	gin? (Spe n, Puerto F	cify Yes or Rican, etc.)	No-	Blac	e - Americ k, White, c whi	etc.
21215-0030	be filed within 72 hours after deeth with the Maryland tall Hygiene.  dother than "natural", or Itema 23e or 28e-f ehow event, Ite Medical Exculter cast be notified at	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)		1-4or 5+)	(Give life. L	lent's Usual Occ kind of work dor DO NOT use reti salespe:	ne during mosi ired)	t of workir	ng	166	o. Kind of Bu	ısiness/Inc	dustry unk
yianaz	2 should be filed and Mental Hygi le marked other aumatic event,	To Be Co	17. Father's Name (First, Middle, Las Harry Holling	ger Kraf	t			18. Mothe	3e11a	Pear	1 F1	den Sumam Letche	r	
nore, mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked ery Injury or other traumatic es one.		19a. Informant's Name/Relationship Pickersgill Retir 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [	ement C	20b. P	615 (	g Address (Stre Chestnut sition (Name of natory or other p	t Avenu	ие То		MD	2120 c. Location -	4	
Бант	permit. Pa Departme Important eny Injury once.		21. Signature of Euneral Service Lice Ronal S	•	rector	S t Ba	Name and Add ate Ana ltimore	tress of Facility  tomy  MD	oard 21201	655 1	W. В	altimo	ore S	treet
	Pnysician /Medical Examiner	iner	23a. Part Enter the disease, or cor shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	caused the death ach line.	phavence of): u		4						Approximate Interval Between Onset and Death M. M. Tho
00/00,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edicai Examine	Cause (Disease of Injury that initiated events resulting in death) Last	c. Due to	or as a consequ	uence of):								
.O. BOX	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregna pirth 2 Fetal lant at time of de own	death 3	Ectopic pregnar Other (specify)				_	23d. Date Mor	e of delive	ry Day Year
ecords, r	equires that sen signed t	by	Part II. Other significant conditions		eath but not rest	•	nderlying cause	given in Part I.			id tobaco	~	ibute to the	e cause of death?
		e Completed	25. Was case referred to medical					00 81		1 ☐ Ye	itopsy erformed s 2	1? 8	Vere autoprior to conteath?	osy findings available inpletion of cause of
ō	Phy this	Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date (Mont		ER/Outpatient 28b. Time of Injury	28c. In	Other: 4 Nu	rsing Hom 2		esidence	9 6 □Othe		)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		3 Suicide 4 Homicide 6 Could not lead to determined	buildi	of Injury - At ho ng, etc. (Specify best of my know	v) wiedge, death	occurred at the	time, date an	d place, a	City or	Town, Si	tate)	nner as sta	Route Number,
	To the How within 24 h To the Fur completely	Medical	(Check only one)  2 Medical Exa  29b. Signature and title I certifier	minar: On the ba	asis of examinat	ion and/or inv	estigation, in my	opinion, deal	th occurre	d at the tim	e, date	and place, a  Date signed	ind due to	the cause(s) Day, Year)
			30. Name and address of person who	110	se of de un (It m	23a) (Type, I	Print)	1 20	۷ - ۵	37	B.	NAY	3,	2004
	Sta Registr		31. Date filed (Month, Day, Year)	/	egistrar's Signa		parks	, with the	~ 6		ja	40.0		

	•	For State Registrar	State of Ma	_	epartment of Certificate o		Mental Hy	/giene Reg. No.	2001	1510
		Registrar     Decedent's Name (First, Middle,	Last)			7 20417	2. Date of D	eath		3. Time of Deatl
Physicia		Mary Cathe		ın			Month May	Day 10,	y Year 2004	2:30P
/Medica		4a. Facility Name (If not institution,			4b. City, Town	, or Location of Deatl	1		. County of Death	2.302
Adminic	1	Oak Crest Re	tirement		Balt	imore			Baltimor	
eral		5. Social Security Number		(In yrs. last birt	hday) If Under 1 Ye Months Day		8. Date of Bi	irth	9. Birthi	place (State or Fore
ector		264-52-0501	1□M 21√2 F 8	39	rs. Worths Da	75 Hours Will.	Dec. 1	1, 1	9. Birthi Coul Mary	land
		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Lim
H	-									1 ☐ Yes 2 ☑
ill i	Scto	Maryland   Baltim	ore	Balti				40 00		
Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Exacting must be middled at once.	Funeral Director	10e. Street and Number 4 Fieldsway C	ourt		10f. Zip Cod	234		_	izen of What Cou ted Stat	-
5	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Decedent of	of Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Americ Black, White,	
National Control	ፍ	1 ☐ Never Married 2 ☐ Marrie  3 ☐ Widowed 4 ☐ Divorced		•	1 ☐ Yes 2 ☐ X		, , , , , , , , , , , , , , , , , , , ,		Specify: Whi	
See .	Completed	15. Decedent's	Education	16a.	Decedent's Usual Oc	cupation	deina	16b. K	ind of Business/In	dustry
Med	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+	)	(Give kind of work do life. DO NOT use rea	ne during most of woi ired)	rking			
4	E O	12	2		omemaker			Ow.	n Home	
vent,	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Nar	•		Sumame)	
tic.	10	James Gately				Adela	ide Fro	nz		
E E		19a. Informant's Name/Relationship			Mailing Address (Stre					Code)
er tre		Mary Angela Lib	erto/Daughte		Fieldsway					
r oth	i	20a. Method of Disposition 1 ☐ Burial ② (X) Cremation	Demousl from State	20b. Place of cemeter	Disposition (Name of y, crematory or other p	olace)	Date	20c. Lc	ocation - City or To	own, State
2 2		4 □ Donation 5 □ Other (Sp.	ecify)	Balt.	Wash. Cre	n. 05/1	2/2004	Lau	rel, Mar	yland
i i i		21. Signature of Funeral Vice L	penage //	2 000.10	22. Name and Ad	dress of Facility Ashton–Mat	thoug F	unor	al Homo	Tno
any ir		Mura Jan	and wood	Sweller's	2134 Wil	low Spring	Road	Balt	MD 21	222
	1	23a Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused	he death. Do r						Approximate Interval Between
ician	4	Immediate Cause (Final			- 1	6		2		Onset and Death
dical		disease or condition resulting in death)	a. Due to (or as a	consequence		ery o	13600			
niner				•	,					
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or murry that initiated events	Due to (or as a	consequence	of):					
ansit	Examin	Cause (Disease or injury that initiated events	C							
the burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence	of):					
e bur	dicai		d							
as th	edi		=							
nse	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o 1 ☐ Live birth 2		3 □Ectopic pregna	DCV.			23d. Date of delive	
d for	icia	in the past 12 months? 1 ☐ Yes 2 No	4☐Pregnant at ti		5 ☐ Other (specify				Month	Day Year
lache	hys	9 ☐ Unknown	9□ Unknown							
e det	y P	Part II. Other significant condition	s contributing to death but	t not resulting in	the underlying cause	given in Part I.	23e. Did	tobacco u	use contribute to t	he cause of death?
been signed by the attending pshould be detached for use as	ed L	atrial	t: pr: 11	atio	<u> </u>		1 🗆	Yes 2	□No 3□Prob	pably 4 Wikno
should	Completed by Physician/Me	hunsel	nsion				24a. Wa		24b. Were auto	psy findings availa mpletion of cause of
page 2	E C	The state of the s						opsy ormad? 2 2 No	death?	
ector, pag		25. Was case referred to medical			<u> </u>	26. Place of Dea	1 Yes		1 Tes	2 NO
irect	o Be	examiner?	Hospital:	t 2 ER/Ou	tpatient 3 DOA	Othor	11	1 2 2 2 2	6 ∐Other (Specif	(se)
aral d	To L	27. Manner of Death	28a. Date of Injury	28b. T		njury at Vork?	28d. Describe			<i>y</i> /
fune fune	ţior	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Year) Ir		Vork? □Yes 2□No				
the	lica	3 ☐ Suicide 6 ☐ Could no	ot be	v - At home, fa	rm, street, factory, offi	ce	28f. Location	(Street an	nd Number or Rura	al Route Number,
i d	erti	4 Homicide determin	building, etc.	*(Specify)			City or To	wn, State	p)	
completely filled in by the funeral director, p	Medical Certification:	(Check only 2 Medical E	Physician: To the best of xeminer: On the basis of e	examination and	, death occurred at the	a time, date and place by opinion, death occu	, and due to the irred at the time	cause(s)	and manner as s	tated. o the cause(s)
the mplet	led	one)	and manner state	ed.	290 Lin	ense number		20d Dat	te signed (Month,	Day Vaar)
0 00	~	29b. Signature and title of certifier	_							
_				MD.		58646 00 Wa		FV(	lay 10,	2004
)		30. Name and address of person v				00 Wa	1 the	2	Boule	Jan 0
1			MD 2	123						
Stat	te	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature						
Registra		M	Y 1 2 2004	plain	. A for	dis.			1	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 23pt. 11&25 per me Gertificate of Health and Mental Hygiene Registrar Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LUCINDA L. KNAPP 2000 /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Baltimore Sougre If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 212-76-8008 1 ☐ M 217 F 44 Yrs. Director 6/7/1959 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "neturel", or Items 23a or 28e-f show the Medical Examinar must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 KNo **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 5 Bexleigh Court, Apt. 3 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Clerk Insurance Company 12 or other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ages 1 and 2 should be file of the file of Health and Mental Health and Mental Health item 27 is marked off Howard T. Epsey Arlene E. Brock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard T. Epsey/Father 2265 Phillips Mill Road, Forest Hill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Importent: If eny injury or once. 5/11/2004 Bel Air Memorial Gardens \* 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Harkins Funeral Home, Inc., 600 Main St., Delta, FA 17314 lions that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. art1, Fint he diseale, or complication, or heart failure. List only he Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) subarachnoid **Physician** /Medical Due to (or as a consequence of): Examiner pertension frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner EXAMINER PPROVED BY MEDIC Due to (or as a consequence of) CERTIFICATIO by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death the 6 Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a

To the Funerel C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res 000 INCLU llen na 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Snapp, Lucinda

MAY 1 2 2004

lapineni

Dr. Sudhahar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Sports &

Franklin Square Drive

		For	State of Maryl	and / Dep	artment of H	lealth and	d Mental Hy	/giene	0001	15100
		1 - State Registrar		Ce	rtificate of l	Death			2004	15132
Physici	an	1. Decedent's Name (First, Middle, Last)	)				2. Date of D Month	Day		3. Time of Death
/Medi	cal	WILLIAM  4a. Fecility Name (If not institution, give	A.	KELI	Y, SR. 4b. City, Town, or	r Location of D	MAY		2004 County of Death	4:42 A. <sup>M</sup>
Examir	ner				TOW:		oatii	10.		מח
Funeral	7.7	1623 HARDWICK ROAL  5. Social Security Number 6. Sec	x 7. Age (In )	yrs. last birthday,	If Under 1 Year	If Under 24 l	Hrs. 8. Date of B	irth	BAL/TIMO	RE plece (State or Foreign ntry)
Director		210-20-0024	M 2 F 71	Yrs.	Months Days	Hours N	7/6/1			/LAND
pue *		Usuel Residence of Decedent  10a. State 10b. County		. City, Town or L	ocation					10d. Inside City Limits
Maryli f sho	ō	MD BALTIMO			WSON					1 ☐ Yes 2 ➡ No
288-	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Cou	ntry?
0036 hours after death with the Maryland tural', or Items 23a or 28a-f show al Examiner rount be notified at		1623 HARDWICK RO	DAD		2128	86			USA	
ier deat Items	Funeral		12. Was Decedent Ever i	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? In. Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ameri Black, White,	
36 safte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No		1 ☐ Yes 2 🔀 No	Specify:			Specify: WHIT	
		15. Decedent's Edu	Year or Dates: KO		edent's Usual Occup	ation		16b. Ki	nd of Business/In	
within 72 ene.	Completed	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired	during most of	working	100.74	10 01 0001100011	iodotty
d with	mo	Elementary/Secondary (0-12)  12TH GRADE	College (1-4or 5+)	SU	PERVISOR			BR	EWERY	
be filed tal Hygin d other	Bec	17. Father's Name (First, Middle, Last)	_				Name (First, Middl		Sumame)	
arylar should b nd Menti marked umatice	70	WILLIAM A. KELLY				HELE	N BUCHMAI	1		
Maryland 21 d 2 should be filed w th and Mental Hygien if its marked other th traumatic event, III		19a. Informant's Name/Relationship (Ty EILEEN T. KELLY			ing Address (Street a					o Code)
C = 0 -	1 8	20a. Method of Disposition	WIFE		3 HARDWICE osition (Name of		TOWSON,	_	21286 ecation - City or To	own. State
Baltimore, bermit. Pages 1 ar Department of Hea Important: If Item any injury or othe		1 ☑Burial 2 ☐ Cremation 3 ☐ F	removal from State		osition (Name of omatory or other place)  CEMETER		14/2004		TIMORE,	
Baltimo permit. Pages Department of Important: If I any injury or once.		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>								HOME, P.A.
Balti permit. Departminuports any inju		M. Sleek	Mane	/	521 LOCH			WSON,		286
		23a. Part1 Enter the disease, of complishock, or heart failure. List only of	lications that caused the c	death. Do not en	iter the mode of dyin	g, such as care	diac or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		CNLM	R ANSR	HYTH	MIA			Onset and Death
/Medical		resulting in death)	a. VENTR1.  Due to (or as a con	sequence of):	1	.,				1-
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led isit	0	Codd Critically list Corrections,		admirate at	//// = /	/				//
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al-tra	xamlr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):	/// = /-					//
760, e be execu sician and e burial-tra	cal Examiner	that initiated events	Due to (or as a con	sequence of):	7,7,27					,,,,,
2 2 2	cal	that intrared events resulting in death) Last	Due to (or as a con	sequence of):						,,,,,
	cal	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a con	asequence of):					23d. Date of delive	•
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Records, P.O. Box 68 The law requires that the death certifical the has been signed by the attending phy page 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a cond.  Due to (or as a cond.  23c. If yes, outcome of present to the second of the s	egnancy Fetal death 3 ( of death 5 ( t resulting in the tell)  2 □ ER/Outpatie (r)  28b. Time of Injury  At home, farm, st	DEctopic pregnancy Other (specify)  underlying cause give  and 3 DOA  of 28c. Injun Work M 1 Creet, factory, office th occurred at the tim nvestigation, in my of	en in Part I.  26. Place of ler: 4 □ Nursin k? Yes: 2 □ No ne, date and pl pinion, death o	23e. Did  1 24a. Wa autopen 1 Yes  Death (Check only 19 Home 5 PRes  28d. Describe  28f. Location City or To	tobacco u  Yes 2  s an  ppsy ormed? 2  No one) how injur  (Street an wn, State e cause(s), date and	Month  Se contribute to to the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second	Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No  al Route Number,  tated.  to the cause(s)  Day, Year)
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certifical ster death. Director: After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a cond.  Due to (or as a cond.  23c. If yes, outcome of present to the second of the s	egnancy Fetal death 3 ( of death 5 ( t resulting in the tell)  2 □ ER/Outpatie (r)  28b. Time of Injury  At home, farm, st	DEctopic pregnancy Other (specify)  underlying cause give  and 3 DOA  of 28c. Injun Work M 1 Creet, factory, office th occurred at the tim nvestigation, in my of	en in Part I.  26. Place of ler: 4 □ Nursin k? Yes: 2 □ No ne, date and pl pinion, death o	23e. Did  1 24a. Wa 24a. Wa 1 Yes  Death (Check only 1 28d. Describe  28f. Location City or To	tobacco u  Yes 2  s an  ppsy ormed? 2  No one) how injur  (Street an wn, State e cause(s), date and	Month  Se contribute to to the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second	Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No  al Route Number,  tated.  to the cause(s)  Day, Year)
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To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions conditions conditions are referred to medical examiner?  1  Yes 2 No 9 Unknown  25. Was case referred to medical examiner?  1  Yes 2 No 9 Unknown  27. Manner of Death  1  Natural investigation investigation investigation of Could not be determined  29a. Certifier (Check only 2 Medical Exemical)  29b. Signature and title of certifier	Due to (or as a cond.  Due to (or as a cond.  Due to (or as a cond.  23c. If yes, outcome of present to the pregnant at time 9 Unknown of the pregnant at time 9 Unknown of the present to	egnancy Fetal death 3 of death 5 ( t resulting in the telephone of the second of the s	DEctopic pregnancy Other (specify)  underlying cause give  and 3 DOA  of 28c. Injun  Work M 1 Direct, factory, office  th occurred at the tim nvestigation, in my of	en in Part I.  26. Place of I er: 4 □ Nursin y at k? Yes 2 □ No ne, date and pl pinion, death o e number	23e. Did  1 24a. Wa autopen 1 Yes  Death (Check only 19 Home 5 PRes  28d. Describe  28f. Location City or To	tobacco u Yes 2 ( s an opsy ormed? 2 (Broet an worn, State e cause(s), date and 29d. Dat	Month  See contribute to to the see contribute to to the see contribute to the see contr	Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No  al Route Number,  tated.  to the cause(s)  Day, Year)

		•	For State Registrar		State	of Mar	yland / D )	epartme C <i>ertifica</i>	nt of H <i>te of i</i>	lealth : Death	and M	ental Hy	giene Reg. No.	2004	15	133
	Physicia	an	1. Decedent's Name (	First, Middle, La:	st)							2. Date of Dea	ath Day	Year	3. Time of 8:05	de.
	/Medic Examin		4a. Facility Name (If n		e street and no	ımber)		4b. City	, Town, o	r Location	of Death		4c. C	ounty of Death		/ 1
			Atlantic						Berli		24 Hrs	0.0		orceste		
	Funeral Director		5. Social Security Nun 218–40–90	94 1	ex XIM 2□F		in yrs. last birth	Months	er 1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da June I	y Year) 19	9. Birth Cou Ma1	place (State o. intry) y Land	r Foreign
	and		Usual Residence of D 10a. State 1	ecedent 10b. County		unk 1	0c. City, Town	or Location							10d. Inside Cit	ity Limits
	Maryi -1 sho	tor	DE			ulik		Se1byv	ille						1 ☐ Yes	2 <b>∑</b> No
	death with the Maryland ims 23a or 28a-f show imust be notified at	Director	10e. Street and Numb	per				10f. Z	ip Code			unk	10g. Citize	on of What Cou		
	ath wi	ral	62 E. Ch	urch St								7 17		USA		
	after or Ite	by Funeral	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 4.		12. Was Dec Armed F 1Yes If Yes, G Year or I	orces? 2 ZNo ive		13. Was Dec If Yes, sp		Specify.		cify Yes or No Rican, etc.)		Race - Amer Black, White Specify: Wh	, etc.	
2-0	72 hours "natural", dical Exa	ted	(Specify	5. Decedent's Ed	ducation	)	16a. [	ecedent's Us	ual Occup	ation	st of workin	na	16b. Kind	d of Business/li	ndustry	
21215-0036	within ene. than "	Completed	Elementary/Second			(1-4or 5+)		Give kind of w life. DO NOT police						law eni	Torceme	n t
9	filed v Hygie other i		17. Father's Name (Fi	irst, Middle, Last,	0			police	OII		er's Name	(First, Middle,			Oreeme	unk
<u>a</u>	Aental Aental rked c	To Be	Leo Jose	eph Lehm	an Sr											
Maryland	12 should be filed within "h and Menta! Hygiene." r ia marked other than "raumatic event, the Mec		19a. Informant's Nam					•				<i>I R</i> oute Number ad Char				622
4	of Health of Health item 27 i		Donna Bo		augnter		20b. Place of I					au Char		ation - City or T		022
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 ☐ Burial 2 ☐ `4 ☐ Donation 5	Cremation 3 ☐ MOther (Specif	y) in st	ate				1						
Ball	Depar Depar Impor any in		21. Signature RO	eral Service Licer na Di S	Wade	Direc	tor	State Baltin	Anat Ore,	omy E	oard 21201	655 W.	Ba1t	imore	Street	
			23a. Part1. Enter the shock, or heart Immediate Cause (Fi	failure. List only	plications that one cause on	each line.		rice .	ode of dyin	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Bety Onset and D	ween Death
	Pnysician /Medical		disease or condition resulting in death)	-	aDue t	(or as a	consequence of	):	-						2 w	WKS.
	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate  b													
77	ted	nine	if any, leading to imm cause. Enter Underly that initiated events	nediate ying jury	Due to	(or as a	consequence of	):								
ć	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) La	st	cDue to	(or as a	consequence of	):								
644 8760	ate be hysicia the bu	dical			_ d											
7/6 7/6 X 68		0)	IF FEMALE:		23c. If yes, or	utcome of	pregnancy						22	ed. Data of dolin		
6/11 5/1/ 0. Bo	he death the atte	Physician/M	23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	nonths?	1 ☐ Live	birth 2 nant at tir	Fetel death	3 □Ectopic 5 □ Other (		/			23	d. Date of deliving Month		Year
768 18, P.	res that the igned by be detact	by	Part II. Other signific	ant conditions	contributing to	death but	not resulting in	the underlying	cause giv	en in Part	l.			e contribute to		leath? Jnknown
2 2	v requir been si should	eted													waren en	
n Re	The law ate has page 2 s	Completed												24b. Were aut prior to c death? 1 ☐ Yes	ompletion of ca	ause of
<i>Е Н</i> 909	Physician: Th r this certificate ral director, paq	Be	25. Was case referre examiner?		Hospital:				Oth			(Check only o			_	
7 , 40	Phys rthis rat dii	. To	1 Yes 2 1	lo	28a. Date	Inpatient of Injury	28b. Ti	me of	28c. Injur Wor	yat		ne 5 🗆 Resid			<i>fy</i> )	
10 10 10	Attending F r death. ector: After by the funera	atlor	1 ⊠Natural 2 ☐ Accident	5 Pending investigation		nth, Day 1	/ear) In	ury M		k? Yes 2 ⊡	]No					
DAVID A18-40 Division	spital or Atte ours after des neral Directo filled in by th	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Flat	e of Injury ding, etc.	/ - At home, fari (Specify)	n, street, facto	ory, office		2	28f. Location (S City or Tox		Number or Rui	al Route Numi	ber,
040	e Hospital or Atten 24 hours after deaf Funeral Director: etely filled in by the	ledical Co		☐ Certifying Pl	niner: On the		xamination and									3)
	To the Hos within 24 ho To the Func completely f	Med	29b. Signature and ti	tle of certifier	el 1	IIII SIAIO	id.	2	9c. Licens	se number	2		29d. Date	signed (Month	Day, Year)	
							0.0	1	449	178	3	-	5//	104		
			30. Name and address		completed car	use of dea	1-23 1/	ype, Print) UNA	is	Dr	N	Be	les	, m	2	
	Sta Registi		31. Date filed (Month	n, Day, Year) 1 2 2004	32. Se,	Registrar'	s Signature	Spa	K							

		1 - For State Registrar	State of Marylar			of Health and of Death	Mental H	ygiene Reg. No. 20	04 1513
Physic /Med Exami	cal	Decedent's Name (First, Middle, Last     Bo Dan Luc     Aa. Facility Name (If not institution, give	ciw		4b. City, Toy	m, or Location of De	2. Date of D Month May	Day	Year 04 9:00 P M
Funeral		St. Johns Communi 5 Social Security Number 6 Se	ty Nursing Ce	last birthday)	Bal If Under 1 Y	timore	Irs. 8. Date of B		Birthplace (State or Foreign Country)
Director		160-26-5089	M 2□F 89	Yrs.			July 1	.5, 1914	Ukraine  10d. Inside City Limits
with the Marylan or 28a-f show be notified at	Director	Maryland  10e. Street and Number			Baltim	de	·	10g. Citizen of W	1 ∑ Yes 2 □ No
be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-1 show event, if a Modical Examiliar is usat be multified at	by Funeral	16 S. Patterson P  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	ark Ave.  12. Was Decedent Ever in U Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		212 Was Decedent If Yes, specify to	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	United  14. Race Black Specify:	States - American Indian, , White, etc. White
od within 72 hours aff gjene. er than "natural", or	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	le completed)  College (1-4or 5+)	(Give	DO NOT use re	one during most of v etired)	vorking	16b. Kind of Bus	
	To Be Co	12 17. Father's Name (First, Middle, Last) Alexander Luciw	4	<u>  Mecha</u>	anical	Engineer  18. Mother's N  Unkno		Enginee  Je, Maiden Sumame	
To, Ivial yiallo	ř	19a. Informant's Name/Relationship (T)  George Luciw - Second	•				Rural Route Num	ber, City or Town, S	itate, Zip Code)
permit. Pages 1 an Department of Heal mportant: if itam 2 iny injury or other 2006.		20a. Method of Disposition  1	Removal from State St	Place of Dispo cemetery, crei Mary tholic	sition (Name of pators or other S UKY. Cemete	rv 5/1	Date 4/2004	20c. Location - C	City or Town, State
permit. Pages 'Department of Himportant: if its any injury or ot ones.		21. Signature ral Service Icens		G G	Name and A	ddress of Facility Kaufman F	uneral H	ome At MM kridge, M	IP., Inc.
Physician /Medical Examiner		23a. Part1. Enter to disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	a		<i></i>	dying, such as card	iac or respiratory	arrest,	Approximate Interval Between Onset and Death
ate be executed hysiclan and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cases. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.						
t the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregn: 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	aldeath 3	]Ectopic pregn ] Other (specify			23d. Date Mont	
w requires that been signed b	by	Part II. Dther significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause	given in Part I.			oute to the cause of death?
The ate h page	Completed						24a. Wa auto per 1 🗌 Yes	opsy pri formed? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Physical distribution	n; To Be	27. Manner of Death	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		Other		one) sidence 6 □Other how injury occurred	
i or Attending after death. Director: After	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	М	1 ☐ Yes 2 ☐ No	28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
Hospita 4 hours Funerai	Medical Ce	29a. Certifier 15 Certifying Phy (Check only one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death	n occurred at the	ne time, date and pla ny opinion, death oc	ce, and due to the curred at the time	e cause(s) and mann , date and place, an	ner as stated. d due to the cause(s)
To the within 2 To the complei	Mec	29h Signature and title of certifier			29c. Lio	cense number		29d. Date signed (	
St Regist	ate	30. Name and address of person who concluded to the state of the state	ompleted cause of death (Iter  32. Registrar's Signa  2 2004	n 23a) (Type,	Print)	eltimere	WW	21230	

LipinsKi, Howard Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760.

		Please	Type or Print in BI		•		-	
		1 - For State Registrar	State of Maryland	I / Department of I Certificate of		l Hygien Rag. N	2001	15130
Physici		Decedent's Name (First, Middle, La.	Howard Franc	cis Lipinski,	Atom		ay Year D 2004	3. Time of Death
/Medio Examin		4a. Fecility Name (If not institution, give	e street and number)	4b. City, Town, o	or Location of Death	4	c. County of Death	
Funeral Director		Franklin Square 5. Social Security Number 216-36-1850		nter Rosec st birthday) If Under 1 Year Months Days	Hours Min. (Mon	of Birth oth, Day, Yea y 14,1	r) Coul	place (State or Foreign
land ow		Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
e-f sh	ctor	Marvland	Baltimore		Middle River			1 ☐ Yes 2X No
th with th	ai Director	10e. Stréet and Number 9901 Van Tassel	Lane	10f. Zip Code	21220		citizen of What Cou nited Sta	
hours after death with the Maryland hours after death with the Maryland .ural', or items 23a or 28e-f show at Examiner must be notified at	by Funeral	11. Marital Status  *X∑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 247No If Yes, Give Year or Dates:	. 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify Yes an, Mexican, Puerto Rican, e Specify:	or No- tc.)	14. Race - Americ Black, White, Specify: W	
"netur	eted	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b.	Kind of Business/In	dustry
within piene. r than	Completed	Elementary/Secondary (0-12)  12 Years	College (1-4or 5+)	Banker	a)	Fe	deral Res	serve
be filectal Hyg	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, M		n Sumame)	
hould I d Men marke matic	ဥ	Howard Francis I		19h Mailing Address /Street	Emma Eva G		or Tourn State 7in	Cadal
and 2 s ealth an n 27 is er traus		Mrs. Marlene E. H	iggins /Sister	7312 Manches	ter Road Dun	dalk,	Maryland	21222
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netur any injury or other traumatic evant, the Madical once.		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 1)	Removal from State	ce of Disposition (Name of metery, crematory or other pla Lawn Cemeter	· .		Location - City or To Baltimore,	own, State , Maryland
ermit. epartm nporta ny inju		21. unature of Funeral Service Lice	and the same of th		ess of Facility Funeral Home	of Du	ındalk, Ir	nc.
		e3a. Part1 Enter the disease, or com	plications that caused the death.	√ 7922 Wise	Ave. Dunda	lk, Ma		21222 Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	ilure		, 2		Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):				
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque		circhosis	5		
executed in and ial-transit	Examiner	triat initiated events	c					
bur be	<u></u>	resulting in death) Last	Due to (or as a conseque	ence of):				
tificate ig phys	ledic		d					-
law requires that the death certificate bas been signed by the attending physic 2 should be detached for use as the b	hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 Ectopic pregnancy	/		23d. Date of delive Month	ery Day Year
res that the igned by the detact	by PI	Part II. Dther significant conditions of	ontributing to death but not result	ing in the underlying cause giv	ren in Part I. 23e.		use contribute to th	ne cause of death?
w require been si should b	eted	Acute Kenal	ta lure	1			No 3□ Prob	
	Completed	cerebral v	ascular d			Was an autopsy performed?	death?	psy findings available mpletion of cause of
ician: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?	Vascala	r diseas	26. Place of Death (Check		o 1 Tes	2L No
disi y	으	1 ☐ Yes 2 No		R/Outpatient 3 DOA Cth	4   Indising Notice 5			()
Attanding I r death. ector: After by the funer	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	lab. Time of lnjury 28c. Injury Wor 1 □	yat 28d. Des k? Yes 2 □No	cribe how inju	ary occurred	
in in	Certification:	3 Suicide 6 Could not by determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Loca City	tion (Street a or Town, Stat	nd Number or Rura te)	l Route Number,
the Hospital nin 24 hours a the Funeral I	Medicai (	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best of my knowl niner: On the basis of examinatio and manner stated.	edge, death occurred at the tir on and/or investigation, in my o	me, date and place, and due to pinion, death occurred at the	time, date an	s) and manner as st nd place, and due to	ated. the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	1 11	29c. Licens	e number	29d. Da	ate signed (Month,	Dey, Year)
		IVIUR A	i cu jy chok	g Res	0000	7.	110/0	14
10		30. Name and address of person who	completed cause of death (Item 2 anskaya, m	D. 9000 Fm	inklin Squar	e. Drive	e Baltim	IOTE MD 2102
Sta Registr		31. Day filed (Month, Day, Year) MAY 1 2 2004	32. Registrar's Signatur	TO Society	-31-33			

DHMH 17 Rev 1/2001

Registrar

			For State	State of N	Maryland / De	epartmer Certifica					-	2001	15136
			Registrer  1. Decedent's Name (First, Middle, Last	·)		, or amou	011	Jean		2. Date of Dea	Reg. No. C	_00=	3. Time of Death
	Physici		McArthur Joseph	,						Month May 4.	Day 2004	Year	2:02 A M
) }	/Medio Examin		4a. Facility Name (If not institution, give		r)	4b. City	, Town, or	Location of	of Death	May 4,		ounty of Deat	
	LXamii	e.	Washington Adventi			Ta	koma	Park			Mor	ntgome	<b>r</b> v
	Funeral		5. Social Security Number 6. Se	x 7. A	Age (In yrs. last birthe		r 1 Year		24 Hrs. Min.	8. Oate of Birtl (Month, Day		9. Birt	hplace (State or Foreign
	Director		229-62-6900	2M 2□F	56 Yr	s. Months	Days	Hours		Nov. 3	194		<sub>untry)</sub> rginia
	p .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	ar Location							10d. Inside City Limits
	anyla shov	2											1 ☐ Yes 2 ☑ No
	Ne W	Directo	Maryland Montgome  10e. Street and Number	ry	Takom	a Park	p Code				10- Citi-	n of What Co	**
	with t	급		. #1500		101. 21		0					untry ?
	eath	era	7600 Maple Ave. Ap	12. Was Deceder		13 Was Dece	2091		igin? (Spe	cify Yes or No-	U.S.A	A . Race - Ame	ncan Indian
ထွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, I'n Medical Examinat must be notified at ance.	y Funeral	1 Never Married 2 Married	Armed Forces 1 Yes 2 If Yes, Give				n, Mexicar Specify:		cify Yes or No- Rican, etc.)		Black, White	e, etc.
ë	ural	d by	3 Widowed 4 Divorced	Year or Dates			-1.0			1		. BT	ack
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0	filled Hygi other	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,			
<u>a</u>	lid be lental ked ked	To B	Raleigh Lewis, Sr	•				Ros	sa Da	vis			
ary	should be stand to some stand to some standard to some st		19a. Informant's Name/Relationship (7)	ype, Print)	19b. N	failing Addres	s (Street a	and Numbe	er or Rura	l Route Numbe	r, City or T	own, State, Z	(ip Code)
Σ	and 2 salth a n 27 l		Mrs. Patricia S. L	ewis_(Wi	fe) 760	0 Maple	e Ave	. Apt	. #1	503 Tak	oma I	Park, 1	D 20912
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from Stat	20b. Place of D	isposition (Na crematory or	me of other plac	θ) 7		ate 3, 2004	20c. Local	tion · City or	Town, State
Ĕ	Pag ment ent: I ury o		`4 □Donation 5 □Other (Specify,		Metropo	litan	Crema	atory	may c	, 2004	Alex.	andria	, VA
Baltimore, Maryland 21215-0036	permit. Depart Import any inj		21. Signature of Funeral Service Licens	attme	cur	22. Name a A L . 515 I	Benn Princ	ett Fess A	uner Inne	al Home St., Fr	, Inc	Čeksbui	rg, VA 22404
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يار	Physician		Immediate Cause (Final disease or condition	Sepsis									Onset and Death  3 Weeks
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	a E											
687	icate phys s the	dical		d									
Box	leath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							230	I. Date of deli	very
ŭ	death a atte	iciai	in the past 12 months?	4☐Pregnant	2 ☐ Fetal death at time of death	3 ☐Ectopic p 5 ☐ Other (s						Month	Day Year
0.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown									
	es tha igned be det	by P	Part II. Other significant conditions co	ntributing to death	but not resulting in the	ne underlying	cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ğ	w require been sig should b	ed	Diabetes Mellitus							1 🗆 Y	es 2⊠N	No 3□Pro	obably 4 ∐Unknown
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ita	cian: ertific actor,	Be	25. Was case referred to medical						of Death	(Check only or	10)		
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Division of Vital Records,	ding Physician: The Ih. After this certificate ha funeral director, page	lo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Oate of In (Month, E	jury 28b. Tim Jay Year) 28b. Tim Inju		28c. Injury Work			8d. Oescribe h	ow injury o	ccurred	
<u>s</u>	or Attendater death Director: in by the	ical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of I	njury - At home, farm			103 2		8f. Location (S	treet and N	lumber or Ru	ral Route Number,
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification;	4 ☐ Homicide determined	building,	etc. (Specify)	,	,,			City or Tow	n, State)		
	Hospital 24 hours 2 Funeral		29a. Certifier 1X Certifying Phy	sician: To the bes	st of my knowledge, o	leath occurred	at the tim	ne, date an	d place, a	nd due to the c	ause(s) an	d manner as	stated.
	ne Ho n 24 l ne Fu	edical	(Check only 2 Medicel Exemi	ner: On the basis and manner	of examination and/o stated.	or investigation	n, in my op	oinion, dear	th occurre	d at the time, d	late and pla	ace, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	11		29	c. License	number	a a	2	9d. Date s	igned (Month	, Day, Year)
•	7		FULL	M			1) 2	20	09		Ma	4	2007
	10		30. Name and Iddress of person who co							_		(	
			Pamela Mulshine,		801 Lockwo	od Dr.	, Si	lver	Spri	ng, MD	20901		
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2 200		strar's Signature	Spe	~ ~						
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			1 State	State of Ma	rylanu / L		te of Death			0.0	101	15107
			Registrar  1. Decedent's Name (First, Middle, L.	actl		Certifica	le oi Dealii		Re Date of Death	g. No	104	3. Time of Death
	Physici	an						1	<b>Month</b>	Day	Year	22:50 PM
Y	/Medic	al	SEUNG JU			4h Cih	, Town, or Location of		YAY (	0.54 <i>o</i> 4c. County	of Doath	22.30
	Examin	er	4a. Facility Name (If not institution, gr	1	Italica	CVI 40. CITY				4c. County	OI Deall1	
	** <u>*</u> ******			MARYLAND 1 Sex 7. Age	(In yrs. last bir	thday) If Unde	BALTIMOV or 1 Year   If Under	24 Hrs   9 F	ate of Birth		9. Birtho	place (State or Foreign
ш	Funeral Director		214.63.9469	1⊠M 2□F	6 4	Yrs. Months		Min.	Month, Day,	Year)	Cour	place (State or Foreign otry) OREA
	6.		Usual Residence of Decedent						411,		17	OKCA
	ylanc Mor		10a. State 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limits
	Mar Mar	tor	MARYLAND BALT	MORE	PARK	< VILLE	=					1 ☐ Yes 2 🔣 No
	or 28	Director	10e. Street and Number	1		10f. Z	p Code		10	g. Citizen of V		ntry?
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or tems 23a or 28a-f ehow ant, the Modical Examinar must be naillfied at	al	3214 B E.	JOPPA K	CAD	2	1234			KOR	EA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Deci	edent of Hispanic Ori ecify Cuban, Mexicar	igin? (Specify n, Puerto Rica	Yes or No- n, etc.)		e - Americ ck, White,	
9	or th	by Fu	1 □ Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	)	1 ☐ Yes	. 1			Specify	. Δ<	MAI
8	urai'	q p	3 Widowed 4 Divorced	Year or Dates:	100	Danadanii 11a	-1.0			Oh Kind of D		-17
7	n 72 nat	Completed	15. Decedent's I (Specify only highest g	rade completed)	16a.	Decedent's Use (Give kind of w life. DO NOT	ork done during mos	st of working	1	6b. Kind of B	usiness/in	dustry
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2	should and Men marke umatic	-	19a. Informant's Name/Relationship	(Type, Print) /	19b	. Mailing Addres	s (Street and Number	er or Rural Roi	ute Number,	City or Town,	State, Zip	(Code) 21234
ž	and 2 salth a n 27 is		MONICA M. L	EE /WI	FE :	3214	BE.	JOPI	A RO	IAD F	PARK	VILLE MD
ē,	s 1 and 2 f Health item 27 i		20a. Method of Disposition		20b. Place of	f Disposition (Na ry, crematory or	other place)	Date		0c. Location -	City or To	own, State
Ë	nii. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ortannet of Health and Mental Hygiene. ortanti: If item 27 is marked other then "natural", or items 23s or 28a-f show injury or other traumatic event, the Modical Examiner must be notified at a.		1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		CXAN	BETUNE	RAY AIR	MAY 7. 6	1004 F	TRECT	HILL	MARVIAN
Baltimore, Maryland 21215-0036	permit. Pages 1 ar Department of Hea Important: If Item any injury or other once.		21. Signature of Funeral Service Lice	ensee	7.17	22. Name a	and Address of Facilit	ity OVAN	JS CH	AREL	OF/	MEMORIES
m	Depa Impo any i		\$ 500 A	Ferrun		880	) HARFO	ORD RE	. PA	RKVILL	EM	D 21234
	*		23a. Part1. Enter the disease, or co- shock, or heart failure. List on	mplications that caused to	he death. Do	not enter the mo	de of dying, such as	cardiac or res	piratory arres	st,		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	Carrel	SHOT	Wow		HEAD				Onset and Death
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	₽ ∺	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	CONSIGNATION .	of):		. 1	///			
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87(		dicai		d			CERTIFICATION ATTA					
x 68	eath certifi attending I I for use as	by Physician/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy		in a second			201.0		
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2	Fetal death	3 □Ectopic p 5 □ Other (s				Mo	te of delive inth	Day Year
o.	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	me or deam	3 L Other (s	pochy)					
α.	res that the de igned by the a be detached f	۳/	Part II. Dther significant conditions	contributing to death but	not resulting in	n the underlying	cause given in Part I	1.	23e. Did toba	acco use cont	ribute to th	ne cause of death?
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Be	he lav e has ge 2	Completed							autopsy perform	ed?	prior to cor death?	mpletion of cause of
a	n: Ti ficate or, pa		25. Was case referred to medical				00 81				1 ☐ Yes	2 <b>№</b> No
	Attending Physicien: r death. ector: After this certific by the funeral director,	To Be	examiner?	Hospital:	2 VERVOL	utpatient 3□ D	Other	e of Death (Ch ursing Home			(Canaih	
Division of	a Phy er this		27. Manner of Death	28a. Date of Injury	28b.		28c. Injury at Work?			v injury occur		77
o	nding tth. :: Afte	atlo	1 □Natural 5 □ Pending 2 □ AgCident investigate	on MAY 04.		njury	Work? 1 ☐ Yes 21☑	No S	ELF IN	FUCTER	1	
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ā	al or A s after of in b	Certification:	4 D Homicide	HOME				32	14 J	oppart	Down	Parthanelle
	Hospital 24 hours 8 Funeral tely filled		29a. Certifier 1 Certifying F	Physicien: To the best of aminer: On the basis of e	my knowledge	e, death occurre	d at the time, date an	nd place, and o	lue to the car	use(s) and ma	inner as st	ated.
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely tilled in by the funeral director, page	Medical	one)	and manner state	ed.			aur occurred at				
	To To	2	29b. Signature and title of certifier	() ()		29	c. License number		29	d. Date signer	d (Month, i	Day, Year)
•	1.		Manue	JUX	M.D.		P 15640		l v	MAY.	5,20	04
	10		30. Name and address of person wh	1			(05-1-					
			31. Date filed (Month, Day, Year)	50250N 32. Registrar		SOUTH	GREENE	57.	BALT	MORE	MD	21201
	Sta Registi		MAY 1 2 2004		4	doa	Sal					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** May 10, Gertrude Loncala 2004 3:46 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 79 1 □ M 2 🔀 F Director 216-14-4768 February 26,1925 MD Usual Residence of Decedent with the Merylenc 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-4 show other traumatic event, the Madical Examinar must be rotified at MD Baltimore 1 ☐ Yes 2 No Edgemere Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 9016 Avenue A 21219 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene.
other than "natural", or ite ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be i Department of Health and Mental i Important: If item 27 is marked of Frank Zubrowski Regina Fryza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward C. Loncala Husband 9016 Avenue A, Edgemere, Md. 21219 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 13, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 2004 Baltimore, Md Injury 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licensee 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part . Enter the disease or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Set only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a BRAIN CANCER Examiner Due to (or as a consequence of): Examine physician and s tha bunal-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): ettending p ed by the detached Part II. Other aignificant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown certificate has been signed lector, paga 2 should be det by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 J Yes 2X. NU Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completaly filled in by the funerel director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 Yes 2 No 4☐ Nursing Home 5☐ Residence 6 NOther (Specify) HOSPICE 28b. Time of Injury 27. Manner of Deeth Date of Injury (Month, Dey Year) 28c. edical Certification: 28d. Describe how injury occurred Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ò 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ŝ 29b. Signature and title of certifier 29c\_License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 2 2004 Registrar

DHMH 16 Rev 6/95

GERTRUDE LONCALA

			For State Registrar	State of Maryla	ind / Dep	artment of F	lealth and l	Mental Hyg	_		15139	
	Physici /Medi		Decedent's Name (First, Middle, Last)     SARA		LEVEN		Day,	2004	3. Time of Death 3:30 A M			
3	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1		ty of Death		
			JEWISH CONVALESCEN  5. Social Security Number 6. Sex		BALTIMO If Under 1 Year	RE If Under 24 Hrs.	10.0(0:4)		LTIMOR			
	Funeral Director	O15 OO O550 10 M 2ME OC Months Days Ho					Hours Min.	8. Date of Birth (Month, Day, SEP. 4,	1907	9. Birthol Coun	ace (State or Foreign try) MD	
	nytano how		10a. State 10b. County		City, Town or Lo					10	Od. Inside City Limits	
	8a-fs	ecto	MD BALTII	MORE	PIKE	SVILLE					1 ☐ Yes 2 🕅 No	
	with the	Funeral Director	7920 SCOTTS LEVEL	DOVD		10f. Zip Code	21208	10	og. Citizen of		try? J.S.A.	
	death ms 23	nera		U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		ice - America	an Indian,		
21215-0036	d within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-1 show the Mudical Examment ust be multified at	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	If Yes, specify Cuba 1 ☐ Yes 2 🕅 No	o Rican, etc.)	Black, White, etc.  Specify: WHITE				
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occup	during most of wor	king	6b. Kind of	Business/Ind	ustry	
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Baltimore,	Pages nent of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 Ø Other (Specify)	lemoval from State	cemetery, crei	matory or other plac ESH BETH	1				MORE, MD	
alti	그런답증 .		21. Signature of Fameral Service Licens			2. Name and Addres			)N & B	ROS.,	INC.	
œ_	Depa Impo any ii		& Suchall	Touge		900 REIST						
J.	Physician /Medical		23a. Part1. Enter the disease, or comblishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ERE	BRAC		g, such as cardiac		st,		Approximate Interval Between Onset and Death	
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687	ficate p phys											
Вох	death certifical e attending phy id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)						23d. Date of delivery  Month Day Year			
P.O.	t the by th lache	hysi	9 Unknown	9□ Unknown								
ecords, F	sign d be	by	Part II. Other significant conditions con	stributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did tobacco use contribute to the cause of deat  1 Yes 2 No 3 Probably 4 No				
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ion	Attending P r death. ector: After i by the funera	atlo	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No					
Division	2 # # E	Certification:	3 Suinida 6 Could not be						eet and Num State)	ber or Rural	Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only one) 2 Medical Examin	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and m te and place,	anner as sta and due to	ted. the cause(s)	
	To the Comp	ž	29b. Signature and title of certifier	. / ^=		29c. License			d. Date signs			
	0		Jasuem	Halleran	)	102	18595		5/1	0/00		
	. 1	17	30 Name and address of person who co	AKHANI, 7	1220	PARK	HEIGH	TS AVE	BA	ero.	MD21208	
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1 2 2004	32. Registrar's Sig	nature	boarles						

			Please	State of Ma						•		_		
	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar Certificate of Death Reg. No. 2004										15140			
	Physicia		1. Decedent's Name (First, Middle, La							2. Date of D Month	eath Day		3. Time of Death	
	/Medic		PRESTON	MCNICI	KEL	5,1	R	Tour or	Location of D	MAY	9	2004 County of Death	235 A M	
}	Examin	er	4a. Facility Name (If not institution, given HARFOAD MEMO)		PITA	<b>)</b>	46. City	, rown, or		GRACE		4ARFO	A D	
	Funeral		5. Social Security Number 6. S	Sex 7. Age		ast birthday)	If Under	or 1 Year Days	If Under 24	Hrs. 8. Date of B			place (State or Foreign	
	Director		353-42-4509	<b>X</b> M 2□ F	56	Yrs.	MOITINS	Days	Hours			948 MISS		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits	
back with the Manual	Maryl	ţō	MARYLAND HARFOR	D CO		ABEI	RDEE	J					1 ☐ Yes 2XXXVo	
	h the	Director	10e. Street and Number		l		10f. Z	ip Code			10g. Cit	izen of What Cou	ntry?	
	ath will		461 RUBY DRIVE			- 1		210			i	U.S.A.	and lading	
	er dez Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No			S. 13.	Was Dec If Yes, sp	edent of His ecify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or Nuerto Ricen, etc.)	10-	14. Race - Ameri Black, White,		
220	urs aft	by F	3 ☐ Widowed 4 ∑ Sivorced	If Yes, Give Year or Dates:	•••		1 🗆 Yes	2 🛣 No	Specify:			Specify: BLA	CK	
5	in 72 hours after death with the Marylan "naturel", or items 23a or 28a-f show siteal Examinat must be nutified at	Completed	15. Decedent's Education 16a. Decedent's Usu (Specify only highest grade completed) (Give kind of wo					ork done di	uring most of	working	16b. K	ind of Business/In	dustry	
7	within ene. then	d m	Elementary/Secondary (0-12)	College (1-4or 5	5+)			use retired) RIVER			MOZ	TING /CEC	DA CE	
N D	77 7 2 2 2 2 2	ပို	12th grade  17. Father's Name (First, Middle, Las.	!)	]	TRU	CK DI		18. Mother's	Name (First, Midd		VING/STO: Sumame)	KAGE	
<u>a</u>	Mental Mental rkad c	To B	PRESTON McNICKL	ES SR					ANNIE	R. McNIC	KELS			
a	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 Is markad othe or other treumatic evant,		19a. Informant's Name/Relationship	(Type, Print)	-	19b. Maili	ng Addres	s (Street a	nd Number o	r Rural Route Num	ber, City o	or Town, State, Zip	o Code)	
e, r	l and lealth mm 27 har tr		Dr. Sheron Finis 20a. Method of Disposition	ter/Sister	20h P	10530 lace of Dispo			183 W	est, Fran		La., 7		
ב ב	Pages 1 av		1 Burial 2 Cremation 3		C	emetery, cre	matory or	other place						
			* 4 □ Donation 5 □ Other (Special Section 21. Signature of Furgral Section 21.	//	HAY	ZES CEI	2. Name :	and Addres	s of Facility	-16-04			ISSISSIPPI	
ñ	permit. Departr Importa any inj		) Julie	sew		W 3	ILLIZ 21 S	AM C I	BROWN (	COMM FUNE IA BLVD,	RAL I ABERI	HOME-HAR DEEN, MD	FORD, P.A. 21001	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li	d the death ne.	n. Do not ent	ter the mo	de of dying	, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Myocardist wyfarction a.											
	/Medical Examiner		resulting in death)	Due to (ogas a consequence of):  b. arterios sellos tes Cardiovascelas decese										
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):	):					yeare				
	cuted nd ransit	Examiner	that initiated events	C										
,09	te be executed ysician and ie burial-transit													
289	physicate to physical street.	dlcal		_ d										
ROX	The law requires that the death certificate ate has been signed by the attending physogge 2 should be detached for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of deliv	•	
	death ne atte ed for	sicla										Month Day Year		
J.	d by the	Phy						23e. Dic	23e. Did tobacco use contribute to the cause of death?					
ďs,	w requires that s been signed b should be deta		Diolete	v)	, , , , , , , , , , , , , , , , , , , ,			g		1	]Yes 2	es 2 No 3 Probably 4 ∰Unknown		
ဝွ	w req	lete	He 10 touring							24a. Was an 24b. Were autopsy findings available				
Vital Records,	Physicien: The lav this certificate has al director, page 2.	Completed							— aul pei 1  Yes	autopsy prior to completion of cause of death?  1 ☐ Yes 2 █ No 1 ☐ Yes 2 █ No				
II	cien: ertifica ector, I	Be	25. Was case referred to medical examiner?	Lia - site is				0#		Death (Check only	one)			
	Physi this c al dire	J.	1 Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpaties			4 LI NUISI	ng Home 5 ☐ Re 28d. Describ			fy)	
0	th. : After	tlon	27. Manner of Death  1 Kautural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) Injury					8c. Injury at Work?  M 1 ☐ Yes 2 ☐ No				milary decembed		
Division of	or Attending Phatter death. Diractor: After the in by the funeral	Certification:	3 Suicide 6 Could not 4 Homicide determine		jury - At ho	ome, farm, st	reet, facto	ory, office	-		(Street ar	nd Number or Run 9)	al Route Number,	
	Hospital or Attending Physicien: 24 hours after death. Funeral Diractor: After this certific tely filled in by the funeral director,											\	No.	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Diractor:	Medical	29a. Certifier 1 Certifying F (Check only 2 Medical Ext	Physicien: To the best iminer: On the basis o and manner st	of examina	wiedge, deat tion and/or in	in occurre ivestigation	on, in my op	e, date and p pinion, death	occurred at the time	e cause(s e, date an	) and manner as s d place, and due t	o the cause(s)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number							29d. Da	te signed (Month,	Day, Year)					
)			Demand 1	Holen Mt	), Du	E		1000	420	6	6 May 9 2804			
	3		30. Name and address of person wh	completed cause of c	death (Item		Print)	/	RD AVE	= BALI	~ An	1 2 12		
	Sta	ete.	31. Date filed (Month, Day, Year)	32 Aegisti		, ,	UIN	KK 0/1	S.10 /1/2	- ロハト	Q 14	U 4/1	C- C	
	Regist			004 See	e h	The state of	BAR.	•						

				partment of Health and Mei		11.1
				ertificate of Death	Reg. No.	1 1 1
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Joseph Francis Molesky		Month Day Year 9:1	of Death
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	Euporal		Edenwald  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year)  Baltimore  9. Birthplace (State Country)	or Foreign
	Funeral Director		215-44-7992 1XM 2□F 95 Yrs		(Month, Day, Year) Country)	PA
	pc ,		Usual Residence of Decedent			
	anylau ehow	_	MD Baltimore Towson	Location	10d. Inside	City Limits es 2 ⊠No
	the M	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	- Au
	with Be or	Di				
	death ms 2:	Funeral	800 Southerly Road  11. Marital Status 12. Was Decedent Ever in U.S. 1	21204  3. Was Decedent of Hispanic Origin? (Specifor Yes, specify Cuban, Mexican, Puerto Ric	United States y Yes or No- 14. Race - American Indian,	
9	or Ite	Ē	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	_		
Maryland 21215-0036	s within 72 hours after death with the Maryland liene. r than "naturel", or tems 23e or 28e-f ehow The Medical Evaria ver must be Indiffied at	d by	3 Midowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify:	Jhite
5	natu	lete	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation we kind of work done during most of working by DO NOT use retired)	16b. Kind of Business/Industry	
12	within lene.	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)	nief of Audit	Internal Revenu	ie
<b>d</b> 2	Hyg Hyg sht,	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maiden Sumame)	
an	od at a	To B	Alexander Modzeleski	Anna K	awalski	
ary	d 2 should th and Men 7 is marke treumetic	ſ-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural R	oute Number, City or Town, State, Zip Code)	
	1 and 2 Health em 27 i				ield, MI 48076	
Baltimore,	to to t		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of Pate Place)	20c. Location - City or Town, State	
Ë	Pa ner ant		`4 Donation 5 Other (Specify) Dulaney	valley Mem. Grans	limonium, MD	
Bal	pernit. Pag Dep rtment Importent: I any injury o		21. Signature of Fyrharal Service Licensee		k Towson Funeral Home,	Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not		uson, MD 21204 spiratory arrest. Approxim	ate
k			23a. Part 1. En er the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		Interval 8 Onset an	etyreen d Jeath
	Priysician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	Vine	,	1
E	Examiner			abstratue hi	ng disene /1	2600
	p ±	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause julisease or injury		0	1)
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c.  Due to (or as a consequence of):			
760,	sician and burial-transit	cal E	Due to (or as a consequence of).			
687	<u>a</u> × a	edic	d		1	
Box (	nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	
	death e atte	icia	in the past 12 months?  1 Vac. 2 No.  4 Pregnant at time of death	B □Ectopic pregnancy □ Other (specify)	Month Day	Year
P.0	at the de by the a tached	Physician/M	9 Unknown			
Vital Records, I	The law requires that the death certifica tte has been signed by the attending phoage 2 should be detached for use as th	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4	
000	aw re as bee 2 sho	ompleted			24a. Was an autopsy finding prior to completion of	s available
Ä		Com			performed? death?  1 Yes 2 No 1 Yes 2 No	Cause Oi
/ita	Phyeicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (C.		
of	Sin	5	1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpat  27. Manney of Death 28a. Date of Injury 28b. Time		5 ☐ Residence 6 ☐ Other (Specify)	
n	ding In. After funer	lon	1 Natural 5 Pending (Month, Day Year) Injur		. Describe how injury occurred	
Division	Attending r death. ector: After by the fune	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		Location (Street and Number or Rural Route Nu	mber.
<u>o</u>	el or Attending Pl s after death. sl Director: After th ed in by the funeral	Certi	4 Homicide determined building, etc. (Specify)		City or Town, State)	
	Hospit 4 hour Funer tely fills	edical (	29a. Certifier (Chack only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed/(Month, Day, Year)	
	0 5	1	I / / / / / / / / / / / / / / / / / / /	10 D2976	9 5/10/04	
1	10/1	)	30. Name and address of person who completed cause of deat (Item 23a) (Typ	e, Print)	1/10	Int
	) (10		wording 1). Moveme	my 5 16 N. R	//ing Rd Bulls	1728
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2 2004  Secure 6	Ann de		,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month <sup>Day</sup>2004 **Physician** 06, Helen C. May 6:30 PM MacMillan /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holly Hill Manor Towson Baltimore If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1□ M 2▼ F Director 174-38-3483 98 March 05 1906 New York Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or itema 23e or 28e-f show traumatic event, the Medical Evanduer must be notified at 1 ☐ Yes 2 X No Md. Baltimore Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5313 Stevenson Lane 21286 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23e eny injury or other traumatic event, the Men Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Curry Ellen Roach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Markum/ Daughter 1695 Deep Run Rd. Whiteford, Md. 21160 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grand View Mem. Park 5-11-04 Annville, Pa. 22. Name end Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner signed by the attending physician and defacthed for use as the buriet-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? roneRerotic cardio vascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours efter death.

To the Funerel Director: Af completely filled in by the fu efter death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗆 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier D57454 Gludeltmen M.D.

1205 York Rd. Lutherville, Md. 21093

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Registrar's Signature

Inna Gendelsman, MD

State Registrar

			For State Registrar	State of Maryland	-	rtment of F			iene <sub>eg. No.</sub> 2001	+ 15143
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physic /Medi		ROBERT	FRANKLIN	MYERS	3		May 6th		5:00 am M
	Exami		4a. Facility Name (If not institution, gi				or Location of Death		4c. County of Dea	
			Reeder's Memo			Boons If Under 1 Year			Washi	
	Funeral Director			Sex 7. Age (In yrs. I. 1 □ M 2 □ F 83	Yrs.	Months Days	Hours Min.	Month, Day	9. Bir 24,1921	thplace (State or Foreign ountry) Maryland
- 1	Maryland f show		10a. State 10b. County	10c. City	, Town or Loc	ation	<del></del>			10d. Inside City Limits
	Mar e-fst	tor	Maryland Wash:	ington B	Boonsb	oro				1 □XYes 2 □ No
	death with the ms 23a or 28e	Oire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
+	ath w	rai	141 South Mai	· · · · · · · · · · · · · · · · · · ·		217			U.S.A	
ů.	er de Items	nue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
_0	rs after	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify: W	hite
Rob	13-0030 172 hours after death with the Marylar netural; or Items 23a or 28e-f show idical Examiner must be resultied at	ed	15. Decedent's E	Education	16a. Deced	ent's Usual Occup	pation		16b. Kind of Business	
7	7	piet	(Specify only highest gr Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(Give k life. D	aind of work done O NOT use retired	during most of worki	ng		•
	giene di	Completed	8		L	aborer			State Hi	ghway Adm.
er.	should be filed within the Market other than market other than matic event, the Market than matic event, the Market than the M	a B	17. Father's Name (First, Middle, Las	•			18. Mother's Name			
	ould Men parke	2		ush Myers			Louis		rtrude	Misack
$\subseteq$	0 2 2 2		19a. Informant's Name/Relationship						, City or Town, State, .	
Ame:	Head Head other		Alice Lavada  20a. Method of Disposition  1 Burial 2 Cremation 3	20b. PI	1284 ace of Dispos emetery, crem	13 St. ition (Name of atory or other place	Paul Road	, Clear	Spring Mo 20c. Location - City or	eryland 2172 Town, State
9)	Dallillo permit. Fages Department of Important: If i any injury or once.	1	'4 □Donation 5 □ Other (Speci	ify) Smit	hsburg	Cremato	rium 05-0	7-04	Smithsburg	. Marvland
ame	Dall permit. Depart Import any inj		21. Signature of Funeral Service Lice	insee					Home, Inc.	,,
2			r. poel	Brady	40	East An	tietam St	reet, H	agerstown.	Md. 21740
	Physician	1 19 20 19	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)			r the mode of dyin		r respiratory arre	est,	Approximate Interval Between Onset and Death
_	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	-	des Veral			
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ		ic Can	oho Veral	en Dir	nan	3m
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events							
-	exection and ital-tra	Exa	resulting in death) Last	Due to (or as a consequ	ience of):					
032	ate be executed hysician and the burial-transit	ical	(	d		<u> </u>				
9	box do	P	IF FEMALE:						!	
2	ath ce	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 E	Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
	Physicien: The law requires that the death certifical price certificate has been signed by the attending price continuity age 2 should be detached for use as it.	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5⊡	Other (specify)			I World	Day Teal
	that the post of t		Part II. Other significant conditions	contributing to death but not resu	Iting in the un-	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
7	w requires been sign should be	ed by	Casertin He	mt Faithm	anon	~ A~		1 □ Ye	s 2□No 3□Pr	obably 4 Alakaown
5	aw re	piet	Direct Aste	- eletions re	spent:	pileni	4	24a. Was ar	24b. Were au	topsy findings available completion of cause of
à	The ate has page	Completed						autops perform	ned?   death?	2☐ No
3	cien: cien: ertific ector.	Be (	25. Was case referred to medical examiner?				26. Place of Death			
5	hyei this c	ို	1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2   E		3□ DOA Othe	er: 4 4 Hursing Hon		nce 6 Other (Spec	cify)
Spread Latin of Witel	fe a	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. Injun Work M 1 []	yat 2 k? Yes 2 ∐No	?Bd. Describe ho	w injury occurred	
.5	r Atte	tific	3 Suicide 6 Could not be determined	28e. Place of Injury · At hor building, etc. (Specify)	me, farm, strei	et, factory, office	2	28f. Location (Str City or Town	eet and Number or Ru . State)	ral Route Number,
Pc	pitel o		29a. Certifier 1☐ Certifying Pi						<u> </u>	
	DIVISION DIVISION Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tu	Medical	(Check only 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinati and manner stated.	on and/or inve	estigation, in my op	ne, date and place, a pinion, death occurre	and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier	T 24 0		29c. License			d. Date signed (Monti	
	m		•	<u> </u>		D (8	0 (9		MAY 6, 2	004
			30. Name and address of person who Dr. Vasant Datta	a, 340 Mills Sti	reet, H		vn , MD 21	.740 3	01-739-710	0
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1 2 200	32 Registrar's Signatu		E)				

			1 - State Registrar	-	aryland / Dep	artment of Hea	ith and M	ental Hyg			1511.1.	
	q		1. Decedent's Name (First, Middle, Last)						ith		3. Time of Death	
	Physici		William Taylor Monks, Sr.			Month 05			09 09	2004	1:50 PM	
	/Medic Examir		4a, Facility Name (If not institution, gi	4b. City, Town, or Loca	ation of Death		4c. Cou	inty of Death				
			14006 Baldwin M	ill Road		Baldwin				ltimore	9	
	Funeral			Sex 7. Age 1. XM 2. F	(In yrs. last birthday)		Jnder 24 Hrs. ours Min.	8. Date of Birtl (Month, Day 11/03/1	n v. Year)	9. Birthp Coun	lace (State or Foreign try)	
	Director		214-20-2726 Usual Residence of Decedent	112 <b>3</b> W 201	95 Yrs.			11/03/1	908	Mar	yland	
	land W		10a. State 10b. County		10c. City, Town or Lo	ocation				1	Od. Inside City Limits	
	Many -1 eh	to	MD Baltin	more	Glen Arn	า					1 ☐ Yes 2 X No	
	r 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?	
	h with	a D	12126 Hooper La	ane		21057			U.S.	A.		
	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-1 ehow he Madical Examinar must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Spe exican, Puerto F	cify Yes or No-	14.	Race - Americ Black, White,		
98	or It	y Fu	1 Never Married 2 Married	1 Tes 2 X			pecify:			ocific		
8	ural',	q p	3 Widowed 4 Divorced	Year or Dates:	1 10 5					AATIT		
15-	"nat	iete	15. Decedent's l (Specify only highest g	education rade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of workir	ng	16b. Kind o	f Business/Inc	tustry	
21215-0036	withi ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	anist			Catho	lic Si	sters Home	
	Hygi other ent,	BeC	17. Father's Name (First, Middle, Las	st)	1.00		Mother's Name	(First, Middle,				
Maryland	tould be filed within I Mental Hygiene. Parked other than	To B								an		
ary	AS OF E	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili					City or Town, State, Zip Code)		
	1 and 2 Health a em 27 ls thar trai		Ruth S. Snyder	(daughter)		Bluestone Co			lle, M	D 2108	37	
ore	of He of Her		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	D	ate	20c. Location	on - City or To	wn, State	
Ĕ	Page ment o ant: If ury or		'4 □Donation 5 □ Other (Spec			Memorial Gd:						
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar to 2052.		21. Signature of Funeral Service Lic	ensee		2. Name and Address of					Str. Sand Standard St.	
_	g 0 5 5 9			sochn		1750 Belair				MD 21	1087	
	Physician		23a. Part1. Enter the disease, of conshock, or heart failure. List online Immediate Cause (Final disease or condition	mplications that caused y one cause on each lin	10.	ter the mode of dying, su	Concie		rest,	5	Approximate Interval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as	a consequence of):	,, ,	Copie C	1			922	
В	Examiner		Sequentially list conditions	b								
	₽ ≔	iner	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury	f any, leading to immediate  Due to (or as a consequence of):								
	te be executed ysician and ie burial-transit	Examiner	Cause (Disease or injury that initiated events consequence of):									
760,	eath certificate be ex attending physician for use as the burial	cal E										
687	~ ~ <u>~</u>			d								
×	certifi nding ise as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d	Date of delive	DV.	
.O. Box	The law requires that the death certifica lie has been signed by the attending ph cage 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)					Day Year	
0	that ned by deta	y P	Part II. Other significant conditions		at not resulting in the u	inderlying cause given in	Part I.	23e. Did to	bacco use c	ontribute to th	e cause of death?	
rds	quires n sign	d by	Renal 1	-Wilve				1 😉 🗸	es 2 No	3 ☐ Prob	ably 4 □Unknown	
Records,	s been si should	Completed						24a. Was a			osy findings available	
Re	The la	E O						autop: perfor		prior to con death? 1  Yes	npletion of occuse of	
Vital	(0	a)	25. Was case referred to medical			26.	Place of Death			10163	110	
>	Physician: this certific ral director,	To B	examiner? 1 Tes 25 to	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3 DOA Other: 4	☐ Nursing Hon	Home sidence 6 □Other (Specify)				
u of			27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time o	f 28c. Injury at Work?	2	8d. Describe h	ow injury oc	curred		
Sio	Attending in death.  ector: After by the fune	atlc	2 ☐ Accident investigati			M 1 Yes	2 🗆 No					
Division	after death Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At home, farm, st c. (Specify)	reet, factory, office	2	8f. Location (S City or Tow		mber or Rura	Route Number,	
	urs af ral D											
	Hosp 24 hor Fune tely fil	Medical	29a. Certifier 1 ☐ Certifying F (Check only 2 ☐ Medical Ext	aminer: On the basis of	examination and/or in	h occurred at the time, da vestigation, in my opinion	ate and place, a n, death occurre	ind due to the c ed at the time, c	ause(s) and late and plac	manner as sta e, and due to	ated. the cause(s)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Med	29b. Signature and title of certifier	and manner sta		29c. License nun	nber	2	29d. Date sig	ped (Month, L	Day, Year)	
	1 × 1 × 0		1	Cerms - 6	un	731	283		5/		1	
7	10		20 Name and address of savess un	n completed cause of d	eath (Item 23s) (Time	Print) 1000	, , ,	0 . //	11	0/0	/	
	V		30. Name and address of person wh	LA Adam	ns 6701	North Cho	les S	+ # 410	1100	JSOM,	Md 21264	
• -7	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	4	-22					

		1 - For State Registrar	State of Marylan	-	rtment of F		-	giene Reg. No 20	04 1514
Dhynia	ion	1. Decedent's Name (First, Middle, Las	1)				2. Date of De Month		3. Time of Death
Physici /Medi		HERB	ERT JAMES	MI	LINER		May		2004 8:53 A
Examir	ner	4a. Fecility Name (If not institution, give			4b. City, Town, o		ath	4c. County	of Death
	-	10 Standard Avenue  5. Social Security Number 6. Se		lant historia	Cri If Under 1 Year	sfield	'S O Date of Die		Somerset
Funeral Director			X M 2□ F 7. Age (III y/s. 76	Vre	Months Days	Hours Mir		y, Yeer)	9. Birthplace (State or Fore Country) Virginia
yland Now		10a. State 10b. County	10c. Cit	y, Town or Lo	ation				10d. Inside City Lim
the Mar 28a-f st	Director	Maryland Somers	et		Cris	field		10g. Citizen of \	1 √ Yes 2 □ I
h with		10 Standard Aven	116			1817		•	USA
deat	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V			Specify Yes or No	14. Rac	e - American Indian,
hours after death with the Maryland lural', or Items 23a or 28a-f show at Exercities innet be rediffed at	þ	1 ☐ Never Married 2 反 Married 3 ☐ Widowed 4 ☐ Divorced	1	ild .	Yes 2 No	Specify:	nto Hican, etc.)		ok, White, etc. White
be filed within 72 hours after death with the Marylan stal Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Madical Examinational be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Deced	ent's Usual Occup kind of work done o O NOT use retired	during most of w	orking	16b. Kind of Bu	usiness/Industry
e filed wi Il Hygien other th	Con	10			Manager				ry Store
be fill d off	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,	Maiden Surnam	тө)
2 should be and Mental Is marked c	70	Oscar B. Milline				Lula Pa			
2 = 12 = 1		19a. Informant's Name/Relationship (T) Dorothy M. Milline					Rumal Route Numbe Crisfiel		State, Zip Code) land 21817
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	Removal from State	emetery, crem	ition (Name of atory or other place	· 1	Date		City or Town, State
permit. Page Department of Important: If sny injury or once.		21. Signature of Funeral Service Licens	2 1194	1/ 22 Fr	Cemetery Name and Addres adshaw &	Sons Fu	neral Ho	me	y, Virginia
· ·		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ishaw-Pruitt lications that caused the death	Do not ente	6 W. Main r the mode of dying	n Street g, such as cardia	- Crisf	ield, Ma rest,	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Multiorgan Due to (or as a consequ	System					Onset and Death  2. Weeks
Examiner		Sequentially list conditions, if any, leading to immediate	Pancreatic	Adenoc	arcinoma	with Lu	ng/Liver	/Spleen	1 month
uted d ansit	Examiner	dairy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ience of).		M€	etastasis	150	
cate be executed physicien and the burial-transit	Ical Exa	resulting in death) Last	Due to (or as a consequ	ence of):					
ficate g phys									
Attending Physician: The law requires that the death certificate be executed robath. robath. sctor: Alth. sctor: page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 □I	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery nth Day Year
res that figned by		Part II. Other significant conditions con	ntributing to death but not resu	Iting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use contr	ibute to the cause of death?
w requires been sign should be	ted by	CHF					1 🗆 Y	es 2□No	3 ☐ Probably 4 ☑Unknow
has be	Completed	DM Type II					24a. Was a	sy p	Vere autopsy findings availab
r. Th		COPD					perfor		eath? □ Yes 2□ No
ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	lospital:		3D DOA Othe	APT.	ath (Check only or		
Phys	To I	1 ☐ Yes 2 ☒ No '	I Inpatient 2 L	ER/Outpatient 28b. Time of	3 □ DOA □ Ours	4   Nursing I	Home 5X Resid		
nding ath. r: Afte e func	atior	t Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	? ′es 2 □ No		on injury occurre	
in the se	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (S City or Town	treet and Numbern, State)	er or Rural Route Number,
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exemi	sicien: To the best of my knowner: On the basis of examination and manner stated.	vledge, death ion and/or inve	occurred at the timestigation, in my op	e, date and place inion, death occ	e, and due to the courred at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
within To the somple	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, Dey, Year)
n-		PHARTER	W		D005	58662		May 3,	2004
3 7		30. Name and address of person who co							
10			os-Tescon, M.D	~ ~					

			1 - For Stata Registrar	State of	Maryland / De	partment of ertificate of	Health a Death	and Mental Hy	/giene200	4 15146
	Physici	an	Decedent's Name (First, Middle	,				2. Date of De Month	Day Yea	3. Time of Death
	/Media		William	Joseph		uire III		May	7 2004	6:20 p M
4	Examir	ıer	4a. Facility Name (If not institution		er)	4b. City, Town,		of Death	4c. County of Di	eath
			1746 Swinburn 5. Social Security Number		Age (In yrs. last birthda	Crofto		24 Hrs. 8. Date of Bi	Anne Ar	
	Funeral Director		220-78-1465	1 <b>X</b> 2XM 2□F	44 Yrs.	Months Days		Min. (Month, D.	ay, Year) 1. 1959 A1	Birthplace (State or Foreign Country) .abama
			Usual Residence of Decedent				11	pcc. 2.	, 1999 111	abana
	irylan show	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	8a-f s	Director		Arunde1	Crofto					1 ☐ Yes XX No
	with the	Pire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	a 236	era	1746 Swinburn	e Avenue	ont Suga in II S 4	2111		ning (Canaita Van an N	USA	nerican Indian,
10	iter d	Funeral	11. Marital Status 1 ☐ Never Married 2 AMArr	Armed Force	9s?			gin? (Specify Yes or No , Puerto Rican, etc.)	Black, W	hite, etc.
8	urs a	by	3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes 2 If Yes, Give' Year or Date	98:	1 ☐ Yes 2XXNo	Specify:		Specify:	White
21215-0036	d within 72 hours after death with the Maryland Jiene, r then "natural", or Itema 23e or 28e-f show It e Madical Examiner must be natified at	Completed	15. Deceden (Specify only highes		16a. De	cedent's Usual Occu	pation	of working	16b. Kind of Busines	ss/Industry
7	c * 3	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	ve kind of work done . DO NOT use retire		or working		
72	a filed within Il Hygiene, other than vent, It e M		17. Father's Name (First, Middle,	(201)	Fina	ncial Pla		r's Name (First, Middle	Finance	
and	be d la b	Be	William Josep		Tw			, , , , , ,	,	
Maryland	d 2 should be th and Mental 7 is marked of traumatic ev	2	19a. Informant's Name/Relations			iling Address /Stree		cannette Ca	er, City or Town, State	Zio Code)
	m E N E		Cindy A. McGu	ire (Wife)					on, MD 211	
altimore,	s 1 and 2 if Health item 27 i		20a. Method of Disposition	<u></u>	20b. Place of Dis	position (Name of rematory or other pla		Date	20c. Location - City	
E	Pages nent of int: If it		XXBurial 2 Cremation 4 Donation 5 Other (S		210			5/13/2004	Davidsonv	ille. MD
alti	permit, Pag Department Important; I any Injury o		21. Signature of Funeral Socice	Licensee		22. Name and Addr	ess of Facility			iiie, iii
<u>m</u>	89 = 58		Jungen	~		12 Ridg	ely Av	enue, Anna	polis, MD	21401
			23a. Part L Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the death. Do not a h line.	enter the mode of dy	ing, such as	cardiac or respiratory a	urrest,	Approximate Interval Between
	Enysician		Immediate Cause (Final disease or condition	6(106	losto ma	MUID	tores	16		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					non
		<u></u>	Sequentially list conditions,	b. Due to for	as a consumence of					
	uted J ansit	Examine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury							
Ć	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					-
8760,	death certificate be executed e attending physician and od for use as the burial-transit	cai		d						
9	ng ph ng ph s as tl	Physician/Medical	IF FEMALE:							
Вох	eath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	BEctopic pregnanc	Э		23d. Date of d Month	elive <b>ry</b> Day Year
0.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□Unknow		i ☐ Other (specify) _			, world	July , July
<u>α</u>	The law requires that the de ite has been signed by the s page 2 should be detached f		Part II. Other significant condition	ens contributing to deal	h but not resulting in the	underlying cause gr	ven in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
ds	uires n sign ld be	d by	Lung me	to tas	65			1 🗆	Yes 2,□116 3□1	Probably 4 Unknown
00	w requires been si should!	Completed	/					24a. Was	an 24b. Were	autopsy findings available
Re	The lav	E O							psy prior to ormed? death?	completion of cause of
ita		ø	25. Was case referred to medical				26. Place	of Death (Check only of	2.☑No 1 ☐ Ye	as ZIMNO
<b>€</b>	S S	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ Inp	atient 2 ER/Outpat	ent 3 DOA Ott	her: 4 🗆 Nur	sing Home 5 Aesi	dence 6 □Other (Sp	recify)
u o			27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date of (Month,	njury 28b. Time Day Year) Injury				how injury occurred	
sio		cati	2 Accident investig	gation oot be			]Yes 2□N		_	
Division of Vital Records,	고 # 는 c	Certification:	4 Homicide determ	ined 289. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location ( City or To	Street and Number or i wn, State)	Rural Route Number,
	spital ours a		29a. Certifier 1 Certifyin	α Physician: To the be	est of my knowledge, de	ath occurred at the ti	me date and	t place, and due to the	cause(s) and manner	as stated
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical one)	Examiner: On the basi and manner	s of examination and/or	investigation, in my	opinion, death	h occurred at the time,	date and place, and di	ue to the cause(s)
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Me	29b. Signature and Itle of certifier	1- N		29c. Licen:	se number		29d. Date signed (Mor	nth, Day, Year)
	(		1/ 18	NO		000	15130	01	May 10	,2004
	N		30. Name and address of person	who completed cause	of death (Item 23a) (Typ	e, Print)	700	1 - (-	1 10 2	1110)
			Kenn Knoft N	10 900 E	estgate 10	0 SUR	500	Annapoli	o MU C	1401
	Sta Registr		MAY 1 2 20		istrar's Signature	10-10	~	,		
			MICH I & ZUI	77		works!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Joseph Markowsk 0702 M /Medical 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gler Burnie If Under 24 Hrs. 8. D 500 haven If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1**X** M 2□ F Hours 219-32-5943 Usual Residence of Decedent Director 6 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23a or 28e-1 show other treumatic event, the Nedical Evanting must be a clifted at 1 ☐ Yes 2 No Director ms 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7500 aven 2106 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 deministration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Markows Joseph Y. Marko rava 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Green Rd., Glen Arm, MD SI 4801 Long Burns Department of Health Importent: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANSFUNERAL CHAPET 5-15-04 20a. Method of Disposition Nethed of Dipposition
 1 ☐ Burial 2 (I) Cremation 3 ☐ Removal from State
 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BALTIMORE MD 21234. eny i Evicta EVANS FUNERALCHAPEL, 8800 HARFORD RD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ton15 UNTING 15CH5R disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 mknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autoosy performed? Yes 2 No 1 ☐ Yes funeral director 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide

Box Division of Vital Records. To the Hospitel or Attending

Medical

filled in by

Registrar

31. Date filed (Month, Day, Year) 1 2 2004

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) JONES, MD /32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Deputy

	ian	Decedent's Name (First, Middle, Last  Mark	o (of slen				2. Date of De Month	Day	Year 2:08)
/Medi Exami		4a. Fecility Name (If not institution, give			4b. City, Town, o	or Location of D	eath May	4c. County	
_ Xaiiiii	101	Howard Count	of aenal H.	opit o	C	(lumbi	·q	HOG	vand county
uneral rector		5. Social Security Number 6. Se 215-10-3284	7. Age (In	yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days		din. 08/05/	T918	Birthplace (State or For Country) MD
>		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or L	acation				104 Inside City I
sho Figure	ŏ								10d. Inside City Li 1 ☐ Yes 2 v
288	rect	MD CARROLL  10e. Street and Number	- 53	WESTMINS	10f. Zip Code			10g. Citizen of W	
38 or	D	403 LONDON COURT	•		21157			U.S.A.	ŕ
BEI S	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes or No Jerto Rican, etc.)	o- 14. Race	- American Indian, k, White, etc.
rel', or Items 23e or 28a-f show Examinatival be indiffed at	5	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 □ No If Yes, Give Year or Dates:		1□Yes 3/□No		20110 1 110411, 010.7		WHITE
"naturel", idical Exe	eted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup	nation	working	16b. Kind of Bu	siness/Industry
Man "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	d)	WOIKING	OUN	HOME
of other than "nature event, the Medical		12 17. Father's Name (First, Middle, Last)		HOME	MAKER	10 Mothada	Name (First, Middle	OWN	
Is marked other eumatic event, I	To Be	MORRIS		КОР	ALD	MATIL		, Maiden Sumami	FINK
ls marke eumatic	1	19a. Informant's Name/Relationship (7					Rural Route Numb		
item 27 other tr		MARA ADKINS / DAU			LONDON CO	OURT W	ESTMINSTE		
= 5		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State		matory or other pla		Date /10 /00 /		City or Town, State
Important: any injury o		' 4 □ Donation 5 □ Other (Specify	·	EBREW YO			/10/2004		AWN, MD
any ir		21. Signature of Funeral Service Licen					SOL LEVIN		-
		23a. Part 1. Enter the disease, or don't spock, of heart failure. List only	oligations that caused the			<del></del>			MD 21208 Approximate Interval Between
sician edical miner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a con  Due to (or as a con  Due to (or as a con	Perfisaquence off.			I perif		Onset and Dea
n and ial-tra	=		d					23d Date	
by the attending physician and tached for use as the burial-transit	hysician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ f 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	′		Mon	of delivery th Day Year
gned by the attending postering to detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  Part II. Other significant conditions co	1 ☐ Live birth 2 ☐ f 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[ of death 5[	Other (specify)		23e. Did t	Mon obacco use contri	th Day Year  bute to the cause of death
been signed by the attending p should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 menths?  1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions of	1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3 of death 5 of death 6 of death	Other (specify)		_ 10'	Mon obacco use contri Yes 2⊟No	th Day Year  bute to the cause of death  G Probably 4 Dunkr
has been signed by the attending p ye 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 mentins? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions co	1 Live birth 2 1 4 Pregnant at time 9 Unknown	resulting in the u	Other (specify)		24a. Was	obacco use contri Yes 2-No :  an 24b. Wossy get get get get get get get get get get	th Day Year  bute to the cause of deatl  Grant Probably 4 Unkr  fere autopsy findings avaitor to completion of cause  sath?
cate has been signed by the attending p page 2 should be detached for use as	e Completed by Physician/Me	23b. Was decedent pregnant in the past 12 mentins?  1	1 Live birth 2 1 4 Pregnant at time 9 Unknown	resulting in the u	Other (specify)	en in Part I.	1 ☐ 1 ☐ 24a. Was auto perfo	obacco use contri Yes 2-No an 24b. We promed? do not contribute the contribute th	th Day Year  bute to the cause of death  3 Probably 4 Unkr  fere autopsy findings availior to completion of cause
is certificate has been signed by the attending p director, page 2 should be detached for use as	Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 mentits? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions or	1 Live birth 2 1 4 Pregnant at time 9 Unknown ontributing to death but not this for the form of the fo	resulting in the u	Other (specify)	en in Part I.	1 1 24a. Was auto perfo	obacco use contri Yes 2-No an 24b. Wo posy primed? 2-No 11	th Day Yea  bute to the cause of deat  3 Probably 4 Unki  (ere autopsy findings ava ior to completion of caus path?
ther this certificate has been signed by the attending prineral director, page 2 should be detached for use as	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 mentins?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions or Club  25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death  1   Natural   5   Pending	1 Live birth 2 1 4 Pregnant at time 9 Unknown Intributing to death but not the first factor of the first f	resulting in the uncertainty of	Other (specify)	26. Place of C	24a. Was autoperformed autoper	obacco use contri Yes 2-No an 24b. Wo posy primed? 2-No 11	th Day Year  bute to the cause of death  B Probably 4 Unkr  fere autopsy findings avaitor to completion of cause  ath?  Yes 2 No
tor: After this certificate has been signed by the attending p the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 mentins?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions or Club.  25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death  1   Natural   5   Pending	Hospital: **Inpatient*  28a. Date of Injury (Month, Day Yea	resulting in the uncertainty of death 5 [  resulting in the uncertainty of the uncertaint	Other (specify)  Inderlying cause give  It 3 DOA Other  M 28c. Injur  Wor  M 1	26. Place of the state of the s	24a. Was auto perfo	obacco use contri Yes 2 No an 24b. W promad? de 22 No 11 one) dence 6 Other how injury occurre	th Day Year  bute to the cause of death  B Probably 4 Unkr  fere autopsy findings avaitor to completion of cause  ath?  Yes 2 No
-unerel Director; After this certificate has been signed by the attending pely filled in by the funeral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 mentits?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions or Necro  25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death 1   Natural   5   Pending investigation   2   Accident   3   Suicide   4   Homicide   Homicide    29a. Certifier   1   Certifying Physical Examiner    20a.   Medical	Hospital:  28a. Date of Injury (Month, Day Yea  28e. Place of Injury (Spiral):  28i. To the best of my	resulting in the uncertainty of the second o	Other (specify)	26. Place of I  ### 4 Nursin  y at  k?  Yes 2 No	24a. Was autoperformer of the control of the contro	obacco use contri Yes 2 No an 24b. W promod? 2 No 11 one) dence 6 Othe how injury occurre  Street and Number wm, State)	th Day Year  bute to the cause of deatl  Growth Probably 4 Unkr  fere autopsy findings avarior to completion of cause eath?  Yes 2 No  r (Specify)  d  r or Rural Route Number,
-unerel Director; After this certificate has been signed by the attending pely filled in by the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 mentits?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions or CLV  25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death 1   Natural   5   Pending investigation   1   Yes   2   No    27. Manner of Death   1   Could not be determined   29a. Certifier (Check only one)   1   Certifying Phylogole   1   Certifying Phylogole   20   Medical Examined   20	Hospital: **Dinpatient*  28e. Place of Injury / building, etc. (Sp	resulting in the uncertainty of the second o	nderlying cause given the state of the state	26. Place of I er: 4 □ Nursin y at k? Yes 2 □ No me, date and pla	24a. Was autoperformer of the courred at the time,	Monobacco use contri Yes 2-No an 24b. W promed? de 2-No 11 dence 6 Other how injury occurre  Street and Number wm, State)  cause(s) and mandate and place, and	th Day Year  bute to the cause of death  3 Probably 4 Unkr  fere autopsy findings avaitor to completion of cause bath?  Yes 2 No  r (Specify)  d  r or Rural Route Number,  mer as stated,  nd due to the cause(s)
Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 mentits?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions or Necro  25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death 1   Natural   5   Pending investigation   2   Accident   3   Suicide   4   Homicide   Homicide    29a. Certifier   1   Certifying Physical Examiner    20a.   Medical	Hospital: Place of Injury Month, Day Yea  28e. Place of Injury Month, Day Yea	resulting in the uncertainty of the second o	nderlying cause given to 3 DOA other (specify)	26. Place of I er: 4 □ Nursin y at k? Yes 2 □ No me, date and place e number	24a. Was autoperformer of the courred at the time,	Mon  obacco use contri  Yes 2-No  an  pormed? 2(2-No  11  one)  dence 6 Othe how injury occurre  Street and Numbe wm, State)  cause(s) and man date and place, and	th Day Year  bute to the cause of death  3 Probably 4 Unkr  fere autopsy findings avait ior to completion of cause saith?  Yes 2 No  r (Specify)  d  r or Rural Route Number, mer as stated, and due to the cause(s)  (Month, Day, Year)
-unerel Director; After this certificate has been signed by the attending pely filled in by the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 mentits?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions or New Yes  25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death 1   Natural   5   Pending investigation   3   Suicide   4   Homicide   Could not be determined    29a. Certifier   Check only one   Medical Examined    29b. Signature and title of certifier   Could use   Could not be determined    29b. Signature and title of certifier   Could use   Could not be determined    29b. Signature and title of certifier   Could use   Could not be determined    20c. No. 1   Could not be determined   Could not be determined    29b. Signature and title of certifier   Could not be determined    20c. No. 1   Could not be determined   Could not be determined    29b. Signature and title of certifier   Could not be determined    20c. No. 1   Could not be determined   Could not be determined    20c. No. 2   Could not be determined   Could not be determined    20c. No. 2   Could not be determined    20c. 2   Could not be determined    20c. 2   Medical Examined    20c. 2   Could not be determined    20c. 2   Medical Examined    20c. 2   Could not be determined    20c. 2   Could not be determined    20c. 2   Medical Examined    20c. 2   Could not be determined    20c. 2   Medical Examined    20c. 2   Could not be determined     Hospital: Impatient  28a. Date of Injury Month, Day Yea  28e. Place of Injury Month, Day Service on the basis of examand manner stated.	resulting in the uncertainty of the second o	nderlying cause given the time of the time	26. Place of I er: 4 □ Nursin y at k? Yes 2 □ No me, date and place pinion, death or e number	24a. Was autoperformer of the control of the courred at the time,	Mon  obacco use contri  Yes 2—No  an	th Day Yea  bute to the cause of deat 3 Probably 4 Unki fere autopsy findings ava ior to completion of caus bath? Yes 2 No  r (Specify)  of  r or Rural Route Number, the cause(s)  (Month, Day, Year)	

# Please Type or Print in Black Indelible lok Ensure All Copies Ar

				State of Maryland / Department of Health and I  1- State Registrar  Certificate of Death	Mental Hygie	_	4 1511.0
		Physic	ian	1. Decedent's Name (First, Middle, Last)  Joseph John Nowakowski	2. Date of Death Month	Day Year	3. Time of Death
		/Medi Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		2004 4c. County of Dea	8:15 A M
		Lxuiiii		Johns Hopkins Bayview Medical Ctr. Baltimore (		N/A	
		Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F 7. Age (In yrs. last birthday) 1 № W 1 □ F 75  1 № Months Days Hours Min.	8. Date of Birth (Month, Day, Y Sept. 13	(ear) 9. Bir	thplace (State or Foreign buntry) aryland
				Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	Dept. 15	7,1520 110	10d. Inside City Limits
		death with the Maryland oms 23e or 28e-f show if mars be notified at	Director	Maryland Baltimore Du	ındalk		1 ☐ Yes 2 🖫 No
		3a or 2	Dire	10e. Street and Number 10f. Zip Code 21222	10g	Citizen of What Co United St	
,		ltems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St	pecify Yes or No-	14. Race - Ame	nican Indian,
4		should be filed within 72 hours after des nd Mental Hygiene. marked other than "natural", or Items matic event, its Madical Examinar in	by Fu	Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No  If Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2 ☑ No Specify:  1 □ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White	
からか	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hou popartment of Health and Mental Hygiene. Important: If Itam 27 ie marked other than "nature eny injury or other traumatic event, Ita Medical E once.	Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired]	king 16	b. Kind of Business	
-0	12	withir ene. than	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		C+ool Tm	de at we
5	d 2	e filed ii Hygi other vent, L		2 Years Field Ironworker Foren 17. Father's Name (First, Middle, Last) 18. Mother's Name	nan ne (First, Middle, Ma	Steel In iden Sumame)	dustry
9	ylar	Menta Menta Merked Mrked	To Be	Joseph Stanley Nowakowski Carol	ine Klei	n	
579 Por	Man	and land		19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rus			
7	e,	1 and Health am 27 ther t			Dundalk,	Maryland c. Location - City or	
B	Baltimore,	ages ant of nt: If it		tCBurial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  Cemetery, crematory or other place)  St. Stanislaus Cemetery 5/		Baltimor	
3	altii	permit. F Departme Importar eny injur		21. Senature of Funeral Service Licensee 22. Name and Address of Facility			114 11 11 11 11 11 11 11 11 11 11 11 11
0	<u> </u>	8858	_ <	Duda-Ruck Funeral 7922 Wise Ave. Du	nome of Dandalk, Ma	undalk, 1 ryland 2	nc. 1222
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			Approximate Interval Between Onset and Death
	100	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a.   MULTIPLE MY E LO M  Due to (or as a consequence of):	<u></u>		LYEAR
	1 4	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	-		
I	ó	te death certiticate be executed the attending physician and hed for use as the burial-transit	Examiner	resulting in death) Last C			
53	68760	certificate be nding physicase as the bu	edicai	\d			
0	Вох	ending r use	M/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	very
4	. 7	es that the death igned by the atten be detached for u	Physician/Med	in the past 12 months?  1   Yes 2   No 9   Unknown   9   Unknown   1   Unknown	Month	Day Year	
3	s, P	w requires that the been signed by th should be detache	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobace	co use contribute to	Ihe cause of death?
7	ecords,	een s			1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
<	Rec	as as	Completed		24a. Was an autopsy performed	prior to d	opsy findings available ompletion of cause of
_<		sician: The lay certificate has rector, page 2		25. Was case referred to medical	1 ☐ Yes 2 🔽		2 <b>2</b> No
7	-5	rnysician: this certific al director,	o Be	examiner?	h (Check only one) me 5 Residence	2 (10)	.,
g		and Proyer.	T : T	27. Manner of Death 28a. Dale of Injury 28b. Time of 28c. Injury at	28d. Describe how in		17)
0	Sion	Attending r death. ector: After	catic	2 Accident investigation M 1 Yes 2 No			
/		s after d in Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rui tate)	al Route Number,
K	200	or the hours after death, within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	, i	within 2 To the complete	Me	29b. Signature and title of certifie 29c. License number	29d.	Date signed (Month	Day, Year)
		$\sigma_{\prime}$		) (Word do ) 1907/		5/10/0 V	
		10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 NEV 7AW C7 (SACT) (MANE M) 21 20)	RIANAN	DAKA	TSHNAN
	76	Star Registra		31. Date MANONIN Day, 2004 332. Registrar's Signature	·		

DHMH 17 Rev 1/2001

			State of Maryland / Der	partment of Health and Mental H	
			. 101	ertificate of Death	Reg. No. 2004 15150
	Dhysisi		Decedent's Name (First, Middle, Last)	2. Date of Month	
	Physici /Medio		ALAN OWENS	may	11, 2004. 7.00 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Northwest Hospital Center	4b. City, Town, or Location of Death	4c. County of Death Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Randallstown  y) If Under 1 Year   If Under 24 Hrs. 8. Date of	Birth 9. Birthplace (State or Foreign
	Director		213-14-2373 <sup>1⊠M 2□F</sup> 84 Yrs.	Months Days Hours Min. (Month, May 5	Day, Year) Country) Maryland
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	Location	10d. Inside City Limits
	Mary a-f sh	tor	Maryland Carroll Woo	odbine	1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show Frust be rediffed at		7200 Woodbine Road	21797	United States
<b>'</b> 0	fter de r Item	Funeral	1 ☐ Never Married 2 ☐ Married   1 ☑ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
8	ours a	þ	1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☐ No 1 Yes, Give Year or Dates: WWII	1 ☐ Yes 2 🔯 No Specify:	Specify: White
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Ind other than "neturel", or Items 23a or 28a-f show event, it e Madical Exercite at a vent, f the vent of th	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given the complete of the complete o	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
12	I withii iene. r than	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	chinest	Federal Gov.
pu	be filed tal Hygie d other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	
yla	2 should be and Mental Is marked e	Tof	Robert Owens	Annie Patter	
Mar	s 1 and 2 should f Health and Men item 27 Is marke other treumatic			ling Address (Street and Number or Rural Route Num W. Old Liberty Road Sy	
	of Health item 27 other tr		20a Method of Disposition 20b. Place of Disposition	position (Name of Date	7kesville, MD 21784  20c. Location - City or Town, State
ê E	Pages nent of int: If iry or		i je bunar z Defination i i memoval rom state	ematory or other place) w Mem. Park May 15, 200	04 Sykesville, MD
Baltimore,	permit. Pages : Department of H Important: If ite any injury or ot				
_	20529		Samuel of courty	22. Name and Address of Facility Burrier-Queen Funeral Ho 1212 W. Old Liberty Road	Winfield,MD 21784
			23a. Part1. Enter the disease, or complications that cause of the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode or dying, such as cardiac or respiratory	y arrest, Approximate Interval Between Onset and Death
	Pnysician /Medical		fease o condition resulting in death)  Due to (or as a consequence of):	213	
	Examiner		Sequentially list conditions b.		
	ed sit	niner	Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury		
-	e be executed rsician and e burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
760,		cal	d		
K 68	The law requires that the death certificate tale has been signed by the attending physic page 2 should be detached for use as the b	by Physician/Med	IF FEMALE:		
Вох	attend for us	ian/	In the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery  Month Day Year
P.O.	the de	hysic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	□ Other (specify)	
	res that the de signed by the a i be detached f	ру Р	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Die	d tobacco use contribute to the cause of death?
ord	w require been sis	ted		1[	Yes 2 No 3 Probably 4 Onknown
3ec	ne law has b ge 2 st	Completed		24a. Wt	as an 24b. Were autopsy findings available prior to completion of cause of death?
Vital Records,	in: Th ificate or, pag		25. Was case referred to medical	1 ☐ Yes	s 20 No 1 Yes 20 No
Ž	ysicia is cert directe	To Be	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check only ant 3 DOA Other: 4 Nursing Home 5 Re	y one) esidence 6 □Other (Specify)
Division of	ng Ph Ifter th		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year) 1 Injury		e how injury occurred
isio	ttendi death.	cat	2. Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	(Street and Number or Rural Route Number,
Ď	after after Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)	City or 7	Fown, State)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only (Ch	th occurred at the time, date and place, and due to the	ne cause(s) and manner as stated.
	the H hin 24 the F mplete	Medical	one) and manner stated.		
	2 × 5 × 5		29b. Signature and title of certifier  The signature and title of cert	29c. License number	May 11 2 0 4 4
1	( )		30. Name and address of person who completed cause of death (Item 23a) (Type		
-	)		HORTHWEST HOSPITAL CENTER	0	no 21133.
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2 2004  32. Registrar's Signature		
	riegisti	ш	WIMI I 6 2004 Statement of	all .	

			1 - For State of Maryland / Dep. State of Maryland / Dep. Ce	artment of Health and M	lental Hyg	Jiene 2004	15151
	Physici		1. Decedent's Name (First, Middle, Last)  Bashir Ahmad Otman		2. Date of Dea Month May	th Day Year	3. Time of Death 10:18 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	пау	9, 2004 4c. County of Death	10:10 A
		J.	6110 Wilson Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Bethesda  If Under 1 Year   ff Under 24 Hrs.	9 Data of Bigh	Montgom	
	Funeral Director		482–42–1189   1 ☑ M 2 □ F   75   Yrs.	Months Davs Hours Min.	8. Date of Birth (Month, Day Feb. 19	Year) Cou	ptace (State or Foreign ntry) Lanistan
	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le				10d. Inside City Limits
	Maryla f sho	tor	Maryland Montgomery Bethes				1 ☐ Yes 2 ☑ No
	n the	lrec	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	ntry?
	ath wil	ralD	6110 Wilson Lane	20817		Inited State	
40	ter de ritems icerte	<b>Funeral Director</b>	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
99	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show the Modical Evaluate in a Refined at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: W	nite
21215-0036	"natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of worki DO NOT use retired)	ing	16b. Kind of Business/Ir	ndustry
212	t withir jiene. r then	omp	Elementary/Secondary (0-12)   Colfege (1-4 or 5+)	il Engineer		Consulting	2
nd	al Hyg	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, I		
Baltimore, Maryland	d Meni d marke metic	2	Not Available  19a. Informant's Name/Relationship (Type, Print)  19b. Mailii		Availabl		
<u>⊠</u>	od 2 sl lith an 27 is r r treur		1111	ng Address (Street and Number or Rura Wilson Lane, Bethe			
ore,	of Hea		20a. Method of Disposition 20b. Place of Dispo		Date	20c. Location - City or To	
Ĕ	. Page tment tent: It			Memorial Park 200	4 F	alls Church	
Bal	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-1 show any injury or other treumetic event, Ite Medical Examples the medical any one.		21. Signature of Funeral Service Lifensee  M00198 75	2 Name and Address of Facility Dbert A. Pumphrey 1 57 Wisconsin Ave.,	Funeral Bethesd	Home/Bethes	sda-Chevy ise, Inc. 3501
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Cardiac Arrest				Onset and Death
	Examiner		Due to (or as a consequence of):  Congestive Hear	t Failure			
	p #	iner	Sequentially list conditions, if any, leading to immediate auto. Enter Underlying Cause (Disease or injury  Due to (or as a consequence of):  Hypertension				
_	xecute and il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  c. Hypertension  Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dical E	d				
9	entificating phy	O I	IF FEMALE:				
Вох	eath certific attending p I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delive Month	ery Day Year
O.	that the de ed by the detached	hyslc	1 Yes 2 No 9 Unknown	Other (specify)			
S, P	es gu	ρλ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		pacco use contribute to the	
Vital Records,	w requir been si should	ompleted					pably 4 ⊠Unknown
Rec	The law cate has by page 2 s	Jump			24a. Was ar autops perforn	y prior to co ned? death?	psy findings available mpletion of cause of
ta		Be Co	25. Was case referred to medical	26. Place of Death	1 Yes 2		2□ No
	S S	2	examiner? 1 🖫 Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatien		ne 5X Reside	nce 6 Other (Specif	y)
O U O	ding Ph h. After th funeral	tlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of finjury	f 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Division of	r Attend er death rector: A by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str			reet and Number or Rura	I Route Number,
Ö	itel or / irs after ral Dire led in b	-	4 Homicide building, etc. (Specify)		City or Town	, State)	
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier  (Check only one)  1 × Certifyi g Ph finlan: To the best of my knowledge, Jeath one)  2 / Medic Exam ner: On the basis of examination and/or in and manner stated.	recentred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the ca ed at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier 54 PF. r	29c. License number		d. Date signed (Month,	,
7	Jo		30. Name and address of person who completed cause of death (ftem 23a) (Type,	D0030791		May 10, 200	4
	.4			sin Avenue #P-9, B	ethesda	, Maryland	20814
4	Sta Registr			pails			

		-	For State	State of	of Marylan		artment rtificate			and M	ental Hyg	iene g. No. 2	004	15152
			Registrar  1. Decedent's Name (First, Middle	, Last)							2. Date of Dear Month		Yeer	3. Time of Death
	Physicia		Ralston Da	le Philli	.ps						May 5,	2004	( 66)	6:40P M
	/Medic Examin		4a. Fecility Name (If not institution						Location o	f Death			ty of Deeth	
П			Anne Arundel Me					_	olis	Od Hen			e Aru	
	Funeral		5. Social Security Number 096–22–7863	6. Sex 1√2 M 2 ☐ F	7. Age (In yrs. 82	last birthday) Yrs.	If Under Months		If Under:	Min.	8. Date of Birth (Month, Day May 20	Ye <i>ar)</i>	9. Birthp Coun	lace (State or Foreign try) nsylvania
	Director	}	Usual Residence of Decedent	Λ	02						May 20	1921	reili	isyrvania
	rland	Ì	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						1	Od. Inside City Limits
	Man a-f sh	tor	Maryland Anne	Arundel			Edge	wate	r					1 ☐ Yes 2XXIo
	or 28	Director	10e. Street and Number				10f. Zip				1	log. Citizen of	f What Coun	try?
	23a		3993 Chesapeake	Drive				210				14.0	USA ace - Americ	on Indian
	tems	Funeral	11. Marital Status	Armed F	cedent Ever in U	i.S. 13.	Was Deced	lent of Hi offy Cubai	spanic Ori n, Mexican	gin? (Spe ), Puerto l	cify Yes or No- Rican, etc.)	BI	ack, White,	
36	rs aff	by F	1 ☐ Never Married ŽXMarri 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2 □ No live Dates: 1939	_45	1 ☐ Yes 2	2 <b>∑</b> No	Specify:			Spec	ity: Whi	te
8	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f ehow Ite Madicel Exemilier transitie notified at	ted t	15, Deceden	t's Education		16a. Dece	dent's Usua	I Occupa	ition	t of work is		16b. Kind of	Business/Inc	dustry
215	hin 72	pie	(Specify only highe Elementary/Secondary (0-12)		) (1-4or 5+)	life.	kind of wor DO NOT us	se retired,	) )	LOL WOLK!	ng .			
2	filed wit Hygiene other tha	Completed		1 year		In	suran	ce I				Afrida - Cura		rance
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle,	Last) L. Phillip	20				18. Mothe		(First, Middle, Inifred		ime)	
<u> </u>	12 should be to and Mental in 7 is marked of raumatic evs	2	19a. Informant's Name/Relations	-	<i>)</i> 5	10h Maili	ina Address	/Street a	and Numbe		I Route Numbe		n State Zin	Code)
Baltimore, Maryland 21215-0036			Melissa S. Phil		<del>-</del> 0	1	3 5		e e		dgewate			
ē,	Health tem 27 other tr		20a. Method of Disposition		20b. I	Place of Disponentery, cre	osition (Nan	ne of ther place	a)	C	ate	20c. Location	- City or To	wn, State
0 E	Pages nent of int: If it iry or o		1 XX urial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5		n State 1	kemont				5-8-0	04	David	dsonvi	lle, MD
alti	그 문학 중		21. Signature of Funeral Service	Ligensee		2	2. Name an	d Addres	s of Facilit	y Ge	orge P.	Kalas	Fune	cal Home
œ	Dermi Depa Impo sny ir	1	19/11/1/1	alle							d Rd. E		er, M	
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that	caused the dea each line.	th. Do not en	nter the mod	le of dying	g, such as	cardiac c	r respiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Seuma									
	Examiner				o (or as a consecutive)	. ,	. 6.		. 64	Sv.		FRAG	rule	10 Days
120	\$	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	o (or as a conse	quence of):	STEA	Cru	C 60~9	9,00		- av	4	0 01143
	cuted od ransit	Examiner	fust lutisted events	C							المونين ،	2 11		
,097	te be executed ysician and te burial-transit		resulting in death) Last	Due to	o (or as a conse	quence of):					X	MI	r	
876	ate b	dicai		d						Ke		PIN	,	
x 68	The law requires that the death certificate the law requires that the attending phy to age 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c If yes, o	utcome of pregn	ancv				1	X	230 0	Date of delive	arv
Вох	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Fet gnant at time of	al death 3	□Ectopic pr □ Other (sp			V	Di	-	Month	Day Year
P.O.	that the death ed by the atte detached for	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk	nown						11.			
	res that igned b	by P	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the	underlying c	ause give	en in Part I		23e. Did to	bacco use co		he cause of death?
ğ	w require been sig should b		LARGE C	246 00	NOTE	or L	-un	<u>.</u>			1 🗆 Y	′es 2□No	3 Prot	bably 4 Unknown
ecc	faw requas been 2 shoul	ompieted	COPD								24a. Was autop	sy	prior to co	psy findings available mpletion of cause of
= R		Con										med? 2 <b>X</b> No	death? 1 ☐ Yes	2□ No
Division of Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital				Oth	or.	1000	(Check only o			
of	Phys this al dii	-T	1 X Yes 2 ☐ No 27. Manner of Death	28a. Dat	e of Injury	ER/Outpatie		DA 28c. Injun	4 🗆 NI	14,1912/1007	me 5 🗌 Resid 28d. Describe h			(y)
uo	ding h. After fune	tion	1 Natural 5 Pendi	/4.4.	onth, Day Year)	Injury		Worl	k? Yes 2. ⊒	No	1=4.	(2) (tan)	61 197 2	NG 70 BEN
IS	Attending it death. ector: After by the fune	ilica	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ce of Injury - At	ome, farm, s	treet, factor	y, office		Ť				al Route Number. esapeake Dr
Ö	al or A s after il Dire	Certification:	4  Homicide	Duli	Iding, etc. (Spec	m 2					Edgewat			400.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		(Check only 2 Medica	ng Physicien: To t Examiner: On the	basis of examin	nowledge, dea	th occurred	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the	cause(s) and	manner as s	tated.
	the thin 24 the F	Medical	29b. Signature and title of cartifi		nner stated.		296	c. Licens	e number			29d. Date sign	ned (Month,	Day, Year)
)	Z 2 2 8						(	75	23	5	57	Ms.	,	201/
	Qi.		30. Name and address of person	who completed ca	use of death (Ite	em 23a) (Type	e, Print)		~~	5		114	6,0	009
	\		Anthony M. Ca					nons	Isla	nd Ro	d. Annar	olis.	MD 21	401
		ate	31. Date filed (Month, Day, Year		Registrar's Sign							,		
	Regist	rar	MAY 1.2	7004 5	Misera	S	400	de	0					

**ORIGINAL** 

		1 - For State of Maryland / Dep Ragistrer	partment of Health and Mental I	Hygiene 2004 1515;
Physic /Med		1. Decedent's Name (First, Middle, Last)  Doc 15 A. Par XR	2. Date o Month	Day Year
Exam	,	4e. Fecility Name (If not institution, give street and number)  6 Arthur Drive  5. Social Security Number  6. Sex  7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Forf Wisshington  y) If Under 1 Year   If Under 24 Hrs.   8. Date of	Trince gentyes
Funera Directo	_	328 28 3535 1 ☐ M 2 ☐ F	Months Days Hours Min. (Month	of Birth of, Day, Year) One  9. Birthplace (State or Foreign Country) New York  10d. Inside City Limits
r 28a-f eho	rector	00	washington	1 ☐ Yes 2/1/No  10g. Citizen of What Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23s or 28s-1 show any nighty or other traumatic event, the Markinal Experiment requires	d by Funeral Director	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	2 ○ 7 + 4 4  Was Decedent of Hispanic Origin? (Specify Yes on If Yes, specify Cuban, Mexican, Puerto Rican, etc)  1 Yes 2 No Specify:	specify: white
Maryland 21215-0036 and 2 should be filed within 72 hours at the and Mental Hylgiene. 27 to marked other then "natural", or reaumatic event, the Medical Exprir	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 4  17. Father's Name (First, Middle, Last)	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)  Stered Nurse	16b. Kind of Business/Industry  Health Care
laryland 212' 2 should be filled within and Mental Hygiene. 1e marked other then aumatic event, the Ma	To Be	Worthen Gillespie	18. Mother's Name (First, Mic Julia Lancas	ter
or Health ar		Lorraine Combs/Pers. Rep. 6904	Livingston Road Oxon H	
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or other		'4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licepsee	Cemetery 5/11/04 22. Name and Address of Facility Geo. F. 160 Oxon 11111 Rd. Oxon	
Physiciar /Medica		23a. Part I Inter the disease, r complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a.		ry arrest, Approximate Interval Between
18760, cate be executed Experience of the buriat-transit in the bu	Examiner	Sequentially list conduints, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	leastic Corphisuascula	r) ssense
cords, P.O. Box 61 w requires that the death certific been signed by the attending p should be detached for use as!	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mookhs? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
ords, Poquires that sen signed bould be deta	b	Part at. Other significant conditions contributing to death but not resulting in the	1	Did tobacco use contribute to the cause of death?
Vital Recc sicien: The law r certificate has be rector, page 2 sh	Completed		p	Vas an utopsy are autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Jn of	atlon: To Be	25. Was case referred to medical examiner?  1		Residence 6 Other (Specify) ibe how injury occurred
Division ital or Attenders after death ral Director: led in by the	Certification;		City or	on (Street and Number or Rural Route Number, Town, State)
Div To the Hospital or A within 24 hours after To the Funeral Direc	Medica	29a. Certifier (Check only one)  1☐ Certifying Physician: To the best of my knowledge, dea (Check only one)  2☐ Medical Examiner: On the basis of examination and/or is and manner stated.	th occurred at the time, date and place, and due to nvestigation, in my opinion, death occurred at the tire.  29c. License number	me, date and place, and due to the cause(s)
)		) or and the state of the state	D 39501	29d. Date signed (Month, Dey, Year)
V		30. Name and address of person who completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 23a) (Type 25a). The completed cause of death (Item 25a) (Type 25a). The completed cause of death (Item 25a) (Type 25a). The completed cause of death (Item 25a) (Type 25a). The completed cause of death (Item 25a) (Type 25a). The completed cause of death (Item 25a) (Type 25a) (Type 25a). The completed cause of death (Item 25a) (Type 25a) (Type 25a). The completed cause of death (Item 25a) (Type 25a) (	Print) 10 5 sagare	Pr D Zamas
Regis	tate trar	MAY 1 2 2004	Source ;	

			1 - For State Registrar	State of Marylai		artment of F			giene 2	004	15154
	Physici	an	1. Decedent's Name (First, Middle, Las	0				2. Date of Dea Month		Year	3. Time of Death
E.	/Media	al	Delores Roche  4a. Facility Name (If not institution, give	street and number		4b. City, Town, o	r Logation of Do		24, 20	004 nty of Death	9:00 AM M
	Examir	er	2901 Edison H				ltimore	dill	46. Cou	niy or Death	
1	Funeral Director		5. Social Security Number 6. Sec 214-01-0969		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Year) 1919	9. Birthr Coul Mary	
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	Od. Inside City Limits
	Maryl Inc	tor	MD		Balti	nore					1X Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen d	of What Cou	ntry?
	ath wi	rai	2901 Edison Hgw				21213		U:		
736	be filed within 72 hours after death with the Maryland ital Hygiene. d other than *natural', or items 23e or 28e-f show event, the Madical Examitter cast by notified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X1 No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	8	lace - Americ Black, White, city: whi	etc.
waryiand 21215-0036	ithin 72 hours ie. ien *neture	Completed	15. Decedent's Ed (Specity only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of w	vorking	16b. Kind of		
2	Hygier Hygier ther th	Co	1 1 17. Father's Name (First, Middle, Last)	0	tele	phone ope			commur		ons
and	@ T D S	Be c	Frederick Hofste	etter				lame <i>(First, Middle, :</i> Stallman	Maiden Sum	ame)	
<u></u>	es 1 and 2 should b of Health and Ment fitem 27 Is marked ir other traumatic e	ဥ	19a, Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street		Rural Route Number	r, City or Tow	vn, State, Zip	Code)
	and 2 salth a n 27 ls		Patricia Cummins,	'daughter				timore, M			
Baitimore,	Pages 1 and ment of He ent: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☒ Donation 5 ☐ Other (Specify,	Removal from State	cemetery, crei	sition (Name of matory or other plac	(e)	Date	20c. Location	n - City or To	wn, State
Balt	permit. Page Department of Importent: If any injury or		21. Signatur Funeral Service Licens	Mull	В	artimore,	tomy Boa MD 21	ard 655 W.		imore	Street
*	Physician /Medical		23a. Part1. Enter the disease, or composition, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ne cause on each line.					est,		Approximate Interval Between Onset and Death
8/60,	the death certificate be executed  y the attending physicien and  when the area as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	b. Corclor of the total of the	dneuce ot):	mentis	ceide	enk			Iwell
O. Box 6	at the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9  Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet: 4 Pregnant at time of o	aldeath 3□	Ectopic pregnancy				Date of delive	ry Day Year
ds, F	es that gned b	by	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.	23e. Did tol	_		ably 4 Unknown
l Record	The law ate has b page 2 sl	Completed						24a. Was a autops perforr	y	prior to cor death?	psy findings available inpletion of cause of 2 No
VITAI	sician: certific rector,	Be (	25. Was case referred to medical examiner?	1 21				eath (Check only on	e)		
6	this al dir	-T	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien	1 100000	4 🗀 Nursing	Home 5 Heside			)
UNISION	ding After fune	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	M 1 🗆		28d. Describe ho	w injury occi	urrea	
2	Dir C	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci				28f. Location (St City or Town	n, State)		
	To the Hospital within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medicel Exam	sician: To the best of my knot ner: On the basis of examina and manner stated.	owledge, death ation and/or in	occurred at the time vestigation, in my op	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and nate and place	manner as st e, and due to	ated. the cause(s)
	To the Ho within 24 I To the Fu completel	Med	29b. Signature and title of certifier	and the second second		29c. License	number	2	9d. Date sign	ed (Month, I	Day, Year)
	, , , , ,		Keinensbell (	appears	O	133	321	1	4	296	4
				ompleted cause of death (Iter	m 23a) (Type,	Print)	1, 4	to7 You	Rd	Suite	309
- 1			CHRISTINE 1	SELL-LAFF	- War	N MK	) L	letyer, 1	re v	ニート	4092
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 9 2004	32. Registrar's Sign	ture An	a Val					7

		1	1 - For State Registrar	State of	Maryland /	-	artment of H				giene Reg. No.	2001	15155
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	cal	4a, Facility Name (If not institution, give s	Janet street and numb	Anna Der)		Renning			May 4,		O4 County of Dea	5:30 PM
1	Exami	iei	7402 Edsworth Roa	ıd			Dunda					Balti	
	Funeral		Social Security Number     6. Sex		Age (In yrs. last t		If Under 1 Year Months Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da)	h v. Year)		thplace (State or Foreign ountry)
	Director		216-36-6231	M 2[3kF	67	Yrs.	monato Bayo			Feb. 2			ennsylvania
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	Mary	į	Maryland Balti	more				Du	ndalk	7			1 ☐ Yes 2€XNo
	th the	Director	10e. Street and Number				10f. Zip Code		22-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-		10g. Citiz	zen of What C	ountry?
	ath wi		7402 Edsworth Ro					212				ed Sta	
	er de:	Funeral		12. Was Deced	es?	13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig n, Mexican	gin? (Spec i, Puerto R	cify Yes or No- lican, etc.)	. 1	<ol> <li>Race - Am Black, Whi</li> </ol>	
36	within 72 hours after death with the Maryland one. Than "natural", or items 23a or 28a-f show he Madical Exeminer must be multiped at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	es: ¥Tuo		1 ☐ Yes 2∳ No	Specify:				Specify:	White
9	72 hours "natural", dical Ext	ted	15. Decedent's Educ	cation		a. Dece	ient's Usual Occupa	ation	4 - 4 and in	_	16b. Kir	nd of Business	/Industry
21	within 72 ene. than "ni	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work done o DO NDT use retired	iuring mosi  )	t or working	g			
121	古るを		12 Years 17. Father's Name (First, Middle, Last)			H	omemaker	40.14-4-		AFTER AND AND A	445745	Own Hor	ne
Maryland 21215-0036	a la de S	Be						18. Mothe		<i>(First, Middle,</i> el Jan:		<sup>Sumame)</sup> U}	in.
Z	d 2 should the and Ment the and Ment to I a marked traumatice	ဥ	James Plank Farri  19a. Informant's Name/Relationship (Ty)		19	9b. Mailir	ng Address (Street a	and Numbe				Town, State.	Zip Code)
			Linda Might / D	aughter			2 Edswort						21222
J.	ss 1 and 2 of Health a litam 27 is r other tra		20a. Method of Disposition		20b. Place cemet	of Dispo	sition (Name of natory or other place	<b>e</b> )	Da	ite	20c. Loc	cation - City or	Town, State
<u>Ĕ</u>	Pag ment ant: It ury o		1 ☐ Burial 2毫 Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from St	are		ervice Co	!	5/6/2	004	TOT	wson, N	Maryland
Baltimore,	permit. Pages 1 a Department of He Important: If Itam any Injury or othe		21. Signature of Funeral Service License	90	mell		. Name and Addres Duda-Ruck 7922 Wise	Fune	eral :	Home of	E Di Marv	undalk, land	Inc. 21222
Е			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that cau	sed the death. Both line.	not ent	er the mode of dying	g, such as	cardiac or	respiratory are	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Arter	ws chr	e ho	. condu	ibo's	cular	, chaea	se		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	e of):							
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence	e of):							
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
0	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or	as a consequence	e of):							
8760,	cate b ohysic the bi	dlcal											
9	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Me	IF FEMALE:	3c. If ves. outco	me of pregnancy						0	2d Data of da	lia
Вох	death a atten d for u	clan	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live birt	h 2 ☐ Fetal déa nt at time of death		Ectopic pregnancy Other (specify)				2	3d. Date of de Month	Day Year
Ö.	that the de led by the a detached f	hys	9 Unknown	9□ Unknow	n								
s, P	es tha igned be del	by P	Part II. Other significant conditions con	tributing to dea	th but not resulting	in the u	nderlying cause give	n in Part I.		23e. Did to	bacco us	se contribute to	the cause of death?
ord	w requires been sign should be									1 🗆 Y	es 2	No 3□P	robably 4 Unknown
Division of Vital Records,	aw Is b	Completed		-						24a. Was a autop:	sy .	24b. Were an prior to death?	utopsy findings available completion of cause of
a F	The ate										2 No	1 Tes	2 🗌 No
₹		o Be	25. Was case referred to medical examiner?  Yes 2 No	ospital:	atient 2 ER/C	Lutantian	t 3 DOA Othe		of Death (	Check only or		Понь / <b>С</b>	-16.1
10	ding Phys h. After this funeral di	n; To	27. Manner of Death	28a. Date of		. Time of	28c. Injury Work	4 🗆 1401		Bd. Describe h		Other (Spe	city)
<u>io</u>	Attending ir death. ector: After by the fune	atio	Natural 5 Pending 2 Accident investigation	(NOTO),	Day (ear)	Injury		r ∕es 2 🗖 ۱	No				
<u>≥</u>	I or Attenc after death Director: I in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At home, , etc. (Specify)	farm, str	eet, factory, office		28	If. Location (S City or Tow		Number or R	ural Route Number,
Ω	Hospital of the state of the st		COn Continue 11 Contituine Physic	iniana Tauta b	-4-6								<u> </u>
	the the	Aedical	29a. Certifier (Check only one) 1 Certifying Phys	ner: On the bas and manne	is of examination a	ge, deatr ind/or inv	estigation, in my op	oinion, deat	place, an	d at the time, d	late and p	place, and due	to the cause(s)
•	To	Σ	29b. Signature and title of certifier  Crossan O	bylovan	- , on D		29c. License	number 076	32	2	M C	signed (Mont	2004
,	3		30. Name and address of person who con T: CROSSIN O"D	mpleted cause	. 6		Print) 12 Du	NDA	LIK A	VE.	BA	-Lro	m) 21222
	Sta	-	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	1							
	Registr	ar	MAY 1 2 2004	Seven	0	100	reter						

*		1 For State Registrar  1. Decedent's Name (First Middle 12)			epartment of I Certificate of	Health and M f Death		Nog. No. 200	4 1515
Physici /Medic Examin	lical iner	Decedent's Name (First, Middle, La BEATRICE     4a. Facility Name (If not institution, ging 348 Melvin Aver	M.  give street and number)  nue Apt.A		4b. City, Town, Catons	or Location of Death	May 9	Day Year	8:15 a M
Funeral Director	t I	5. Social Security Number 6.		ge (In yrs. last birthda) 75 Yrs.	Months   Days	s Hours Min.	(Month, Day,	9 Birt	irthplace (State or Foreign Country)
h the Maryland or 28a-1 show	Urector	10a. State 10b. County M.D. Baltimo		10c. City, Town or Catonsv	ville 10f. Zip Code		1	10g. Citizen of What Co	
be filed within 72 hours after death with the Maryland tal Hygiene. It has not then than "natural" or items 23a or 28a-f show event, tra Medical Examinar must be notified at	by Funera	348 Melvin Aver  11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces?	Ever in U.S. 13	2122  13. Was Decedent of N If Yes, specify Cub  1 Yes 2 No	f Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	U.S.A  14. Race - Ame Black, White Specify: B1	nerican Indian, ite, etc.
filed within 72 hours af Hygiene. other than "natural", or ent, the Medical Engin	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 10th  17. Father's Name (First, Middle, Lasi	Education grade completed) College (1-4or 54	(Giv	ecedent's Usual Occup live kind of work done 'e. DO NOT use retire COOK	te during most of worki red)	rking	16b. Kind of Business/ Jennings  Maiden Sumame)	s/Industry Cafe
ed fa b	To Be	William Gait	ther (Type, Print)		ailing Address (Stree	Mary H	lammond	Maiden Sumame) r, City or Town, State, 2	Zip Code() 1 2 2 8
permit. Pages 1 and 2 should Department of Health and Men Important: If term 27 is marke any injury or other traumatic once.		Frances Brown—  20a. Method of Disposition  1	☐Removal from State	20b. Place of Disposementery, com	Melvin A sposition (Name of crematory or other pla Crematory	Avenue A	Apt.A, Ca Date 2 2/2004	atonsvill 20c. Location - City or Balto., M	Le, M.D. r Town, State M.D.
permit Depar Impor any ir		23. Part1. Enter the disease, or comshock, or heart failure. List only	E VIII	d the death. Do not e	2501 Gwyr	nnsfalls	Rkwy, B		ome Inc. e.M.D. 2121 Approximate Interval Between
death certificate be executed  We are as the burial-transit  A for use as the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Security is condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a a	a consequence of):  a consequence of):  a consequence of):	Heart Millet with a	failus TI			Onset and Death
at the death certifica by the attending phacehed for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o  1  Live birth 2  4 Pregnant at ti 9 Unknown	2 Fetal death 3	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	;y		23d. Date of deline Month	blivery Day Year
w requires that the been signed by should be detail	by	Part II. Other significant conditions of	contributing to death bu	ut not resulting in the	underlying cause gr	ven in Part I.		pacco use contribute to	o the cause of death?
sician: The law requires the contificate has been signed inector, page 2 should be contificate.	Completed						24a. Was an autopsy performe	y prior to o death?	utopsy findings available completion of cause of
of a fitending Physician: The law requires that the satier death. I Director: After this certificate has been signed by the din by the funeral director, page 2 should be detached in by the funeral director.	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day		e of 28c. Injur y Wor M 1	ther: 4 Nursing Hor ury at 2 ork? Yes 2 No	28d. Describe how	ence 6 □Other (Spec ow injury occurred	
F 8 F C	al Certif	4 Homicide determined	building, etc.	of my knowledge, dea	eath occurred at the tir	time, date and place, a	City or Town,	use(s) and manner as	hatata a
To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29b. Signature and title of certifier	aminer: On the basis of e	Mysticial	29c. Licens	opinion, death occurre	rred at the time, date	ate and place, and due of the signed (Month,	e to the cause(s)
_)	tate	30. Name and address of person who Dr. Miguel Here 31. Date filed (Month, Day, Year)	edia,M.D.	413 Com			Balto.,	M.D. 212	28

			For State Registrar	State of M	aryland / I	Depa <i>Cei</i>	artment of F	lealth and N Death	Mental Hyg	iene2004	15158	
			1. Decedent's Name (First, Middle, L	ast)					2. Date of Deat	h	3. Time of Death	
	Physici /Medic		Nellie				R:	nker	Month	Day Year	4 10:00 PM	
	Examin		4a. Facility Name (If not institution, gr	Α.	1 1 7	ء ام		Location of Death		4c. County of Dea	th	
					dial (el	Her	If Under 1 Year	HMUre If Under 24 Hrs.	8. Date of Birth	N/A	41-1	
г	Funeral Director		217-34-9621	1 M 2 XF	67	Yrs.	Months Days	Hours Min.	(Month, Day, February	13, 1937 V	thplace (State or Foreign ountry) A	
	פ		Usual Residence of Decedent							V <sub>i</sub>		
	anylar show	-	Md. Baltime	220	10c. City, Tow	vn or Lo ndal					10d. Inside City Limits 1 ☐ Yes 2 🕅 No	
	the M	ecto	10e. Street and Number	же	Dui	Iuaı	10f. Zip Code		14	0g. Citizen of What C		
	72 hours after death with the Maryland ineturel', or Items 23a or 28e-f show dical Evaminar must be notified at	Funerai Director	7510 School Aven	ue			2122	2	1,	USA	ountry?	
	r deal	ner	11. Marital Status	12. Was Decedent Armed Forces?	?	13. \	Vas Decedent of H	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi		
36	rs afte	<b>by</b> Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 🔀 If Yes, Give Year or Dates:	No		∏Yes 2X No	Specify:		Specify: W		
21215-0036	2 hou eture	ted	15. Decedent's E	ducation	16a	. Deced	lent's Usual Occup	ation		16b. Kind of Business	/Industry	
215	thin 7 e. en "n	Completed	(Specify only highest g. Elementary/Secondary (0-12)	rade completed)  College (1-4or	5+)	life. I	kind of work done of NOT use retired	during most of work ()	ing		•	
	ed wii		12 years			Secu	rity Gua			Pinkerton	Security	
Maryland	I be fii ntal H ed ott	Be	17. Father's Name (First, Middle, Las Garwood E. Wagne:	•				18. Mother's Name	e (First, Middle, N Thompson	,		
ΪŽ	should nd Me mark metic	T <sub>o</sub>	19a. Informant's Name/Relationship		196	o. Mailin	g Address (Street			City or Town, State,	Zin Codel	
	nd 2 saith ar 27 is r treu		Robert C. Rinker	son			-			, Md. 2122		
ore,	of Head		20a. Method of Disposition	Domewol from State	20b. Place o	of Dispo	sition (Name of natory or other place	9)	Date 2	20c. Location - City or	Town, State	
Ĕ	Page ment ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		1	-			4,2004 M	iddle Rive	er, MD.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23a or 28e-f show eny injury or other treumetic event, the Medical Evanter must be notified at once.		21. Signature of Funeral Service Lin	onsee Corval	Oly	7	onneily 110 Solle	uneral Hers Point	Ome Of D Road, D	rundalk,P.A rundalk,Md.	21222	
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	the dath. Do						Approximate Interval Between	
	Pnysician	) i	Immediate Cause (Final disease or condition	^	nonia						Onset and Death	
	/Medical Examiner		resulting in death)			one week						
	Lammer	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Chrun	a consequence		uctive	Pulmone	7938	ten years		
	uted I Insit	Examiner	Cause (Disease or injury									
ó	cate be executed physician and s the burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):						
8760,	ate be nysicia he bu	dicai		_ d.								
9		Med	IF FEMALE:		,							
Вох	that the death certifi ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy			23d. Date of del	ivery Day Year	
o.		ysic	1 ☐ Yes 2 ∰No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death	٥٢	Other (specify)					
s, P	signed b	y Pr	Part II. Other significant conditions	contributing to death b	out not resulting i	in the ur	iderlying cause givi	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
rds	The law requires that the ate has been signed by the page 2 should be detache	Completed by	End stage 1	enal dise	45C				1 <b>⋤</b> Ye	s 2□No 3□Pr	robably 4 🗆 Unknown	
Vital Record	e law re has bed je 2 sho	piet							24a. Was an		utopsy findings available completion of cause of	
Ä	The lav	Com							perform	ied? death?	2□ No	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	-		04	26. Place of Death				
of	Phys this al di	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Minpatio	ent 2 ER/Ou	utpatien Time of	3 ☐ DOA Oure 28c. Injury		me 5 Resider 28d. Describe ho	nce 6 Other (Spe	cify)	
Division of	ding Phy th. After thi funeral	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Da		Injury	Worl	(? Yes 2 □ No	200. Describe no	w injury occurred		
Visi	Atten r dea ector by the	ifica	3 Suicide 6 Could not determined	28e. Place of Inj	ury - At home, fa	arm, stre	eet, factory, office		28f. Location (Str.	eet and Number or Ru	ıral Route Number,	
Ö	tel or s afte el Dir	Certification:	4   Homicide	bullding, et	c. (Specify)				City or Town,	State)		
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edicai (	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination an	e, death	occurred at the timestigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier				29c. License	number	29	d. Date signed (Monti	h, Day, Year)	
•	di		Upsette Brown	, M.O., Fh.D			RES -	000	m	ay 11, 200	4	
	\"		30. Name and address of person who Lynette Bracon, Form					Worfe . B.	Himere	MD 2128	7	
	Sta Registr	-	31. Date filed (Month, Day, Year) MAY 1 2 2004	32. Registr	ar's Signature	1	Kal 1					
			111 1 4 CUU4	A PARTY OF THE PAR	N /	41800	an i					

			For State Registrar	State	of Marylan	id / Depa <i>Cer</i>	artment of tificate o	Heal	th and I ath	Mental H	ygien Reg. N	e 20	04	15	159
·	Physici /Medio		1. Decedent's Name (First, Middle, Horace J. S	amples						2. Date of I Month May 3	, 20	Ó4	/eer	3. Time of 2:40	
7	Examir	er	4a. Facility Name (If not institution, 100 Revolut	ion Stre	et #611		4b. City, Towr Havre	de G	race		Н	c. County of arfor			
	Funeral Director		5. Social Security Number 215-26-6130 Usual Residence of Decedent	6. Sex 1 💢 M 2 🗆 F	7. Age (In yrs. 95	last birthday) Yrs.	If Under 1 Ye Months Day		nder 24 Hrs. urs Min.	8. Date of the Month Mar 1.	Birth Day, Year	909	Penr	ace (State of isylvan	r Foreign n <b>i</b> a
JU36	be filed within 72 hours after deeth with the Maryland lat Hygiene. d other than "natural", or Itams 23a or 28a-1 ahow event, the Madical Examinar must be natified at	d by Funeral Director	10a. State 10b. County  MD Harfo:  10e. Street and Number  100 Revolution  11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced	n Street	#611 cedent Ever in U orces? 213 No	.S. 13. V	e de Gr	1078 of Hispaniuban, Me	c Origin? (S xican, Puert ecity:	pecify Yes or I o Rican, etc.)		USA  14. Race- Black, Specify:	at Count	an Indian, stc.	-
9500-61212 b	filed within 72 Hygiene. ther then "ne int, the Medic	e Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 8	College	(1-4or 5+)	(Give life. L	lent's Usual Occ kind of work do DO NOT use ret dairy f	ne during ired) arme	r	rking me (First, Midd		Kind of Busi  agricu  n Sumame)	ı1tur		
Maryland	2 should and Men in marke aumatic	To Be	Thomas David  19a. Informant's Name/Relationsh	ip (Type, Print)			g Address (Stre		umber or Ru					,	
Baltimore, M	1 an Heal em 2 ther		Nancy White/d.  20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 ፟ሺDonation 5 □ Other (Sp	3 □Removal from	1 7	Place of Dispo	Revolut sition (Name of natory or other p		Street	Date	+	e de G			2107
Baltii	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service L Ronald	* -	irector	r St Ba	Name and Ada ate Ana Itimore			d 655 W	. Ba	ltimo:	re S	treet	
94/60,	Physician and // Medical Examiner and physicien and physic	dical Examiner	e3a. Party. Enter the disease, of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sha Due to b. Due to	caused the deat each line.  AND (CO) (or as a consequence of the conse	uence of):		tying, suc	h as cardiad	c or respiratory	arrest,			Approximate Interval Betwoonset and Doctor	ween Death
C. Box c	it the death certiff by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 □ Feta nant at time of d	I death 3	Ectopic pregna Other (specify)				-	23d. Date of Month		,	'ear
Vital Records, P	requires tha been signed should be de	Completed by Pl	Partl. Other significant condition  Myelody Splass  Prostade cance	19	death but not res	ulting in the ur	nderlying cause	given in F	Part I.	1 [ 24a. Wt au pe	Yes 2	24b. We	Proba	e cause of dealbly 4 U	Inknown
ō	nysicien: nis certifica i director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death    Natural 5 Pending investig	28a. Date (Mo	Inpatient 2  of Injury oth, Day Yeer)	ER/Outpatien 28b. Time of Injury	28c. Ir		☐ Nursing H	ath (Check only iome 5 Re 28d. Describ	sidence	6 Other			
DIVISION	To the Hospitel or Attending Py within 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral	Certification:	3 Sutcide 6 Could n 4 Homicide determin	ned 286. Place	e of Injury - At he ding, etc. (Specif	y) 					own, Stai	te)			70 <i>r</i> ,
	the Hospi in 24 hou the Funer spletely fill	ledical	(Check only 2 Medicel E	Physician: To the xaminer: On the and ma	e best of my kno basis of examina nner stated.	wledge, death tion and/or inv	estigation, in m	y opinion,	, death occu	, and due to the	e, date ar	nd place, and	d due to	the cause(s)	
1	To t	M	29b. Signature and title of certifier  Peashort	Shull		~~	}	ense num U Y E			29d. D	ate signed (	Month, D	Pey, Year)	
			30. Name and address of person v Prashant Shu	ikla, no	155.	Parke S	treet#	400	Abe	rdeen.	no	2100	١		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 2 2004	Sens.	Registrar's Signa	yore A	pach								

			1 - For State Registrar		Department of Health Certificate of Death	and Mental Hygier	ne 2001 15160
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, L JOHN R 4a. Facility Name (If not institution, gi	SCOTT	4b. City, Town, or Location	MAY	Year 3. Time of Death County of Death N/A
	Funeral Director		5. Social Security Number 6. 213-32-4493	Sex 7. Age (In yrs. last 152) M 2   F 68	birthday) If Under 1 Year If Under 1 Year Wonths Days Hours	r 24 Hrs. 8. Date of Birth (Month, Day, Yea July 27,	Birthplace (State or Foreign
	perint. Tages I and 2 should be used when 72 hours also bearn with the manyarid bearn with the manyarid bearners of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic avant, the Madical Examinat must be nutified at once.	ai Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Bal  10e. Street and Number  2530 Lodge Fore	timore	own or Location  10f. Zip Code 212		10d. Inside City Limits 1 ☐ Yes 2☑ No  Citizen of What Country?  nited States
0000	ious alter use iral', or items L'Examination	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Korean	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☑ No Specify		14. Race - American Indian, Black, White, etc. Specify: White
TC1212	Hygiene. Rhygiene. Ither than "natural", int, Ithe Madical Exa	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12) 12 Years	Education 1 rade completed)  College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)  Millwright	st of working	Kind of Business/Industry
	and Mental Hy	To Be	17. Father's Name (First, Middle, Las  John E. Scott			veronica Pot	ock
Ĕ (	Health and I sem 27 is ma		Mrs. F. Irene S  20a, Method of Disposition	cott / Wife	19b. Mailing Address (Street and Numb 2530 Lodge Forest e of Disposition (Name of	Drive Edgeme	ere, Maryland 21219  Location - City or Town, State
_	Definit. Trayes Department of the important: If its any injury or of one one one one one one one one one one	1	1 ★ Burial 2 □ Cremation 3 ↓ 4 □ Donation 5 □ Other (Spec	□Removal from State Gard	ens of Faith Cem.	5/10/2004 Ro	sedale, Maryland
ם	Depa Impo any ii		11)en.	C. Caul	7922 Wise Ave.	Dundalk, Mar	ndalk, Inc. yland 21222
	hysician /Medical :xaminer		Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.  SEPSIS  Due to (or as a consequen	Oo not enter the mode of dying, such a		Inferval Between Onset and Death Well
	been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, badmig to min educate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Diles to (or as a consequent d.			
O. DOX O	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 ☐Ectopic pregnancy		23d. Date of delivery Month Day Year
CCOLOS, T	en signed bould be det	by	Part II. Other significant conditions  LORGNAY ARETE	contributing to death but not resulting VY DISEASE	g in the underlying cause given in Part		ouse contribute to the cause of death?
אוומו חפכר	2 2 0	Completed	AND-STAGE RE	WAL DISPASE	, Ity PARTOVSION	24a. Was an autopsy performed 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
NA IO IIOIS	within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ıtion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of De th  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28	Other	e of Death (Check only one)  ursing Home 5 \sum Residence  28d. Describe how inj  No	
DIVIS	within 24 hours after death.  To the Funeral Director: A completely filled in by the funeral process.	Certification:	3 Suicide 6 Could not determined	d building, etc. (Specify)		City or Town, Sta	
	the Funer	Medicai	one)	Physician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurred at the time, date a and/or investigation, in my opinion, de	ath occurred at the time, date ar	nd place, and due to the cause(s)
, i	Con	M	29b. Signature and title of certifier	S MD	29c. License number	4 Ma	ate signed (Month, Day, Year)  y  0 2004
4	Sta	to	30. Name and address of person who WBNDY BENN DI 31. Date filed (Month, Day, Year)	32. Registrar's Signature	ASTOCN NE. 1	BARMORE	MP 21224
	ા Registr		MAY 1 9 2004	he deve !	land.		

			1 - For Stata Registrar	State of Ma	ryland / I	Departme Certifica			Mental Hy	giene Reg. No. 20 (	04 15161
	Bloom in i		Decedent's Name (First, Middle, Last	)	1	1	~		2. Date of De	eath	3. Time of Death
	Physici /Medio		James Phi	111p 5	tew	ert	JR		May	6 20	1 1
	Examin		4a. Facility Name (If not institution, give	street and number)	1 Marala		y, Town, or I	Location of Dea	-	4c. County of	
			Johns Hopkins Bayvin 5. Social Security Number 5. Se	2W Medica	(In yrs. last bi	ethelay) If Une	der 1 Year	L ( TIMC		N/	
	Funeral Director			Yu one	66	Yrs. Month		Hours Mir			9. Birthplace (State or Foreign Country) Kentucky
			Usual Residence of Decedent						0 427 1	, 2337	
	arylar show	J.	10a. State 10b. County		10c. City, Tow						10d. Inside City Limits 1 ☐ Yes 2 ☑No
	he M.	Director	Maryland Balt  10e. Street and Number	imore			dalk Zip Code			10g. Citizen of W	
	ath with the Marylan s 23a or 28a-f show unt by retified at	I Dir	501 Wise Avenue			101. 2	Zip Code	21222			l States
	death ms 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was De	cedent of His		Specify Yes or No rto Rican, etc.)		- American Indian,
9	after dea or Itams	Fui	1 ☐ Never Married 2X Married	Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give			ecity Cuban 2⊠ No		no Hican, etc.)		, White, etc.
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Itams 23a or 28a-1 show event, the Medical Exerting roust by recified at	d by	3 Widowed 4 Divorced	Year or Dates: 1						Specify:	White
15-	n 72 n	Completed	15. Decedent's Edu (Specify only highest grad	de completed)		. Decedent's U: (Give kind of I life. DO NOT	sual Occupat work done du use retired)	tion uring most of we	orking	16b. Kind of Bus	iness/Industry
212	i within liene.	omp	Elementary/Secondary (0-12) 12 Years	College (1-4or 5-	+)	Wel				Steel	Industry
	be filed tal Hygie d othar evant,	o l	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle	, Maiden Sumame	
ylar		To B	William Stewart					Hatt	ie M. Os	sborne	
Maryland	s 1 and 2 should f Health and Mer itam 27 Is marks othar traumatic		19a. Informant's Name/Relationship (T) Mrs. Laura A. Ste			o. Mailing Addre			Rural Route Numb	er, City or Town, S	itate, Zip Code) 222
	s 1 and f Health itam 27 othar t		20a. Method of Disposition		20b. Place o	f Disposition (A	lame of		Date		City or Town, State
nor	8 ° = 5		1X Burial 2 ☐ Cremation 3 ☐ 1 '4 ☐ Donation 5 ☐ Other (Specify,			ry, crematory o		em. 5/1	0/2004		le, Maryland
Baltimore,	_ F F F		21. Signature of Funeral Service Licens		our de.					f Dundalk	
ñ	Departiment Department		Vent al							Maryland	
			23a Part1. Enter the disease, or comp shock, or heart ailure. List only of	lications that caused ne cause on each lin	the death. Do						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. cereb	ral h	ernia	tion				Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a	consequence		110.00				7 /
		Į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	Cere	of):	Hem	100011C	rge		1 aays
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,	/-			9		
oʻ	te be axecuted ysician and ie burial-transit		resulting in death) Last	Due to (or as a	consequence	of):	-				
68760		Ical		d							
	death cartificat e attending phy d for use as th	Physician/Med	IF FEMALE:	72a H.von autenma	f program						
Вох	attend for us	slan	in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death	3 □Ectopic 5 □ Other				23d. Date Mont	,
P.O.	0 0	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	sile of death	o di lei (	3pocity)				
	law requires that the as been signad by th 2 should be detache	by Pł	Part II. Other significant conditions co	1	_	n the underlying	cause giver	n in Part I.	23e. Did t	tobacco use contrib	oute to the cause of death?
ıd	w require been sig should b	ed k	coronary arte	ry disel	ise,	nype	rtens	510n	1 🗆	Yes 2□No 3	Probably 4 Hnknown
Records,	e law re has be je 2 sho	ompleted	grabetes						24a. Was		ere autopsy findings available or to completion of cause of
<u>~</u>	Th ate pag	Con								ormed? de	ath? ☐Yes 2☐ No
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	-	ath (Check only		· ·
of	Phys rrthis aral di	To ti	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Minpatier 28a. Date of Injury	28b.	tpatient 3 1	28c. Injury	4 🔲 (Yulsing		dence 6 Other how injury occurred	
ion	Attanding I ir death. actor: After by the funer	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury M		es 2□No		, , ,	
Division	or Attandi after death. Diractor: A In by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc.	ry - At home, fa	arm, street, fact	ory, office		28f. Location ( City or To		or Rural Route Number,
ā	ital or A	Cer									
	To the Hospital or Attanding Ph within 24 hours after death.  To tha Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	rsician: To the best o iner: On the basis of and manner stat	examination ar	e, death occurre id/or investigation	ed at the time on, in my opi	e, date and place nion, death occ	e, and due to the urred at the time,	cause(s) and mani date and place, an	ner as stated. d due to the cause(s)
	To th withii To th comp	Me	29b. Signature and title of certifier	0 1-4		2	9c. License			29d. Date signed	(Month, Day, Year)
	,		265 g.	imyc,	20		RES-	000		MAY 7	,2004
5	XH		30. Name and address of person who c	CUMBA4GH		(Type, Print)	1 Ena	frn A	ionio B	a Honoro	MD 21224
	Sta	te	31. Date filed (Month, Day, Year) MAY 1 2 2004	32. Registra		///(	1 UW		LINCHER	01/1/1981	IND CITET
	Registr	ar	MM1 1 % 2404	persone	D	Span	S				

		1 - For RegistrarAMFND TIFM #14	State of Mary					ne . No. 2004	15162
Physic /Med		1. Decedent's Name (First, Middle, Last	Salam		alamo	a de la compa	2. Date of Death Month	Day Year	
Exam Funera Directo	1	4a. Facility Name (If not institution, give Upper Chesapeake  5. Social Security Number  142-48-6086	Hospital	n yrs. last birthday) 61 Yrs.	Edgewo	r Location of Death  Ood  If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Harfor  Harfor  9. Bin Co	
### Maryland with the Maryland a or 28a-1 show Le notified at	irector	Usual Residence of Decedent	10	e. City, Town or Lo			10g	. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🏋 No
er death Items 23	by Funeral Director	301 Caspian Ct  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		2104 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spean, Mexican, Puerto		U S A  14. Race - Ame Black, Whit  Specify: FG	
Maryland 21215-0036 at 2 should be filed within 72 hours atter the and Mental Hygiene. 27 is marked other than "natural, or Ite traumatic event, the Medical Examilia	Completed by	15. Decedent's Edit (Specify only highest grade Elementary/Secondary (0-12) 12th grade  17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5+) Master's	(Give	dent's Usual Occup kind of work done of DO NOT use retired SPECTOT	during most of worki		Health	Industry onal Safety
aryland 2 should be filed and Mental Hygic is marked other unaffice event, if	To Be	Salama Abdul Haha  19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street a	Sania K	adous		Zip Code)
imore, Ma Pages 1 and 2 ment of Health a ant: If item 27 is		Amy Omayma Salama  20a. Method of Disposition 1 🖫 Burial 2 🗆 Cremation 3 🗆 F	2	20b. Place of Dispo		Ct Edgewo		21040 c. Location - City or	Town, State
Baltimore, Bartimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens				rk 5-7-2 ss of Facility Ma Wabash	rch F/H	andallstor West Balto, Md	
68760, Wedica Examiner Approximation and as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	onsequence of):		g, such as cardiac of Infur			Approximate Interval Between Onset and Death
Box.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
/ <b>v</b> 8 5 8		Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	_	the cause of death?
	e Completed	25. Was case referred to medical					24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2  No
Sn of ling Physical distributed distribute	ToB	examiner?  1 Yes Yatural  27. Manner of leath  Satural 5 Pending  2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	28b. Time o Injury	28c. Injury Work	4   Nursing Hor		e 6	esty)
Divis  Divis  Intal or Attents after des  Instal Director  Instal Director  Instal Director	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)			City or Town, S		
Division or  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Medical	25a. Cartifier (Check only one) 2 Medical Examinate one) 29b. Signature and title of certifier	sician. To the best of mer: On the basis of exa and manner stated	amination and/or in	vestigation, in my or	pinion, death occurre	ed at the time, date	e(s) and manner as and place, and due  Date signed (Month	to the cause(s)
16	)	30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type,	Print) 500 U	pper Ct	esapeat	e Dr Bela	2004 in Md
S Regis	tate trar	31. Date filed (Month, Day, Year) MAY 1 2 2004	32. Registrar's	Signature	1.	11	1		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** May B, 2004 8:24 am M David Charles Snyder /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 17,1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 □ F 386-26-9837 84 Michigan Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Department of Health and Mental Hygiene, Institutal, or Itams 23e or 28a-f show Important: if item 27 is marked other than "natural, or Itams 20e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at appear. Once. 1 ☐ Yes 2√☐ No Director Howard Ellicott City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 2660 Legends Way 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yès, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margaret Healy David Snyder ပ John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, Maryland 21042 2660 Legends Way Anne Marie Snyder / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 □Donation 5 □ Other (Specify) St. John's Cemetery 5/12/04 Ellicott City, Md. 21. Signature of Funeral Service Censes 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 Carl A. an 23a. Part1. Enter the disease for complication shock, or heart failure. Vist only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. s after death. investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1550% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD BALTIMORE MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2004

DAVID

SNYDER,

S SAUER - MAY 7, 2004 (a) 6:104M.
Division of Vital Records. P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No 2 0 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:10 A<sup>M</sup> Louis G. Sauer May 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 98 Director 215-03-6310 1905 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f show item 27 is marked other then "netural", or Items 23a or 28e-f shov other treumatic event, the Medical Examinal must be notified at 1 Yes 2 No Director Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10535 York Road Completed by Funeral 21030 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other then "netural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Builder Home Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Η. Sauer Elizabeth Goetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 item 27 I 914 Breezewick Road Lou Adelman Daughter Mary Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley <u>=</u> 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Importent: If eny injury or once. \* 4 ☐ Donation \_ 5 ☐ Other (Specify) 5-7-2004 Memorial Gardens Timonium Maryland 22. Name and Address of Facility 21. Signa Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician Severe bullous emphy sema lear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No Director; After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Hospitel or Attending 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Balt Md 21204 BMC 6701

Registrar

31. Date filed (Month, Day, Year)

MAY 1 2 2004

32 Registrar's Signature

			For State Registrar	State of Maryland	-	artment of H				14 1516	5
			Decedent's Name (First, Middle, Last	1)				2. Date of Dea	th	3. Time of Deat	th
	Physicia /Medic			Mildred Anna	Skvar	na		Month May		Year 004 9:25 A	M
	Examin		4a. Facility Name (If not institution, give	street and number)			r Location of Death		4c. County o	f Death	
			Riverview Nurs			Essex				timore	
	Funeral		5. Social Security Number 6. Se	TH OFFE	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Fore Country)	eign
	Director	}	218-28-2790 Usual Residence of Decedent	90				July 1	+ 1913	Maryland	
	yland now		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Lim	nits
	Mar-fal	tor	Md. Harford	យ	hitefo	rd				1 □ Yes 2 □	ίNο
	or 28	Director	10e. Street and Number			10f. Zip Code		1	l 0g. Citizen of Wi	· ·	
	72 hours after death with the Maryland traturel; or Items 23a or 28a-f show dical Examinar must be nutitivu at	rai	1894 Deep Run				1160			USA	
	er deg	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of I f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- p Rican, etc.)		- American Indian, , White, etc.	
36	rs afte	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify:	White	
Ş	turel		15. Decedent's Ed	ucation		dent's Usual Occup			16b. Kind of Bus		
212	within 72 iene. then "na he Medi	plet	(Specify only highest grad	de completed) College (1-4or 5+)	(Give life. l	kind of work done DO NOT use retire	during most of wor d)	king			
21	d with	Completed	12	30.10 <b>3</b> 0 (1 10.101)	Store	e Manager	•		Turkes	Store	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. I Health and Mental Hyglene treams 23a or 28a-f show item 27 is marked other then "naturel, or Items 23a or 28a-f show other treamstic event, the Medical Examinar must be notified at	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, i		)	
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Nar	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (7				and Number or Ru				
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Baltimore,	permit. Pages I Department of h Important: If ite any injury or ot	- 1	21. Signature of Funeral Service Licens		-	. Name and Addre	ss of Facility			.111, 1714.	1.7
B	permi Depa Impo any ii		1	2		Ruck Tou	son Fune: k Rd. To	ral Home	, Inc.		
			23a. Part1. Enter the disease or come shock, or heart failure. List only of	dications that caused the death	. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory arr	est,	Approximate Interval Between	
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	/Medical		resulting in death)	Due to (or as a consequ	uence of):	) 1	bail		•		
	Examiner		Sequentially list conditions,	b. Chmm		enal	back	ve.			
-	ed isit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	dence or):						
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8760,	ate be executed hysician and the burial-transit	- a		d							
9	tificat ng phy as th	Medica									
Вох	leath certific attending p	an/N	236. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	v			of delivery th Day Year	
	it the dea by the att tached fo	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify)		· · · · · · · · · · · · · · · · · · ·	Mont	th Day Year	
P.O	that the	Phy	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I	23e. Did to	bacco use contrib	oute to the cause of death?	?
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Ö	w requir been si should	ete						24a. Was a	24h W	ere autonsy findings avails	able
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<u> </u>	Physicien: r this certific ral director,	To B	examiner? 1 Yes 2 Mo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	at 3□ DOA Ott	ner: 4 Aursing H	ome 5 Reside	ence 6 Other	(Specify)	
	ng Phys fter this neral di		27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	y at rk?	28d. Describe ho	ow injury occurre	d	
Sio	Attending r death.	catio	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division	or At after d Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str /)	eet, factory, office		City or Town	treet and Numbei n, State)	r or Rural Route Number,	
4	pital ours sours serel filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, death	occurred at the ti	me, date and place	, and due to the c	ause(s) and man	ner as stated.	
	To the Hos within 24 ho To the Fun completely	edical	(Check only 2 Medical Examone)	iner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my	ppinion, death occu	rred at the time, d	late and place, ar	nd due to the cause(s)	
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,	1-1	1	\$ 01	and			30641		May 1	11 2004	
J	1/18		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) K Q1	ver Nec	K Roc	od Ba	Itimore May	Ilan
	Sta	ato.	31. Date filed (Manth. Day, Year)					7, 7,00		Staz	1
	Registi		31. Date filed (MAY). $\hat{\mathbf{Z}}^{ay}$ , $\hat{\mathbf{Z}}^{eac}$ 2004	Squa	B	Spark	/				

Decided Name   First Models, Last    Decided Name   First Name   Section   Decided Name   Program   Decided Name   Decided N				1 - For State Registrar	State of Maryla	ind / Depa <i>Ce</i>	artment of F rtificate of	lealth and <i>Death</i>	l Mental Hygi	ene g. No. 2004	15166
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Section   Control   Cont		g. T	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons		OP CI CS	> '''	C11107		) (412
Section   Control   Cont		cuted nd transit	amir	that initiated events	с						
FFEMALE   23b. Was decedent pregnant in the past 12 months?   1   Ves 2   28h. No   9   Unknown   23c. If yes, outcome of pregnancy   1   Che bits 12   25c. If yes, outcome of pregnancy   1   Che bits 12   25c. If yes, outcome of pregnancy   1   Che bits 12   25c. If yes, outcome of pregnancy   1   Che bits 12   25c. If yes, outcome of pregnancy   1   Che bits 12   25c. If yes, outcome of pregnancy   1   Che bits 12   25c. If yes, outcome of pregnancy   1   Che bits 12   Che bits 12   Che bits 12   Che bits 13   Che bits 14   Che bits 14   Che bits 15   Cher (specify)   23c. Date of delivery   Month Day Year   1   Ves 2   No 3   Probably 4   Chert of the cause of death?   1   Ves 2   No 3   Probably 4   Chert of	90,	De exe	EX	resulting in death) Last	Due to (or as a cons	equence of):					
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O C SP THE SECRETION SINCE SERVING SINCE SER		nding use as	n/Me				-			23d. Date of delive	ery
Total   State   Stat		death	slcia	in the past 12 months? 1 ☐ Yes 2 ☑No	4☐Pregnant at time of			· 		Month	Day Year
1   Yes   2   No   3   Probably   4   Unknown	P.0	d by the	Phys						On Didash		4 4-440
25. Was case referred to medical examiner?  1		signe d be d		Part II. Other significant conditions co	ntributing to death but not r	esuiling in the u	nderiying cause giv	en in Pan I.			
25. Was case referred to medical examiner?  1	Ö	w requ been shoul	lete						· (		nev findings available
25. Was case referred to medical examiner?  1	Re	The la te has age 2	ошо						autopsy perform	prior to con death?	inpletion of cause of
The state of the s	ita		a					26. Place of D			ZACJ NO
Second Process of Pending investigation   Second Process of Pending in	∑ <	hysic this ce	၉	1 ☐ Yes 2⊠No	1 inpatient 2		1 3 DON	4 Z Indiani			y)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093	n C	ding P	lon:	1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury			28d. Describe how	v injury occurred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093	isic	Attender death cotor:	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Pface of Injury - At	home, farm, str		163 2 110			l Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093	D	al or safter	Certi	4  Homicide	building, etc. (Spe	cify)	,,		City or Town,	State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093		Hospit 24 hours Funera etely fille		(Check only 2 Medical Exami	ner: On the basis of exami	nowledge, death nation and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the cau curred at the time, dat	ise(s) and manner as si e and place, and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093		To the within To the	Me	29b. Signature and title of certifier	1 0 1	\	29c. Licens	e number	290	d. Date signed (Month,	Day, Year)
ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093		>		Inestine	Wingh	A Mi	1 0	52	140	11/cmy 10	JW 500 A
Divide 12 in		10						Y ROAD	TIMONIUM	MD 2109	3
State 31. Date filed (Month, Day, Xear) 32. Registrar's Signatore		Sta	te.	31. Date filed (Month, Day, Xear)	32. Registrar's Sig	<b>1</b>	ports				

1:00 P.M.

MAY 10, 2004

SCHUERHOLZ, DORIS

State of Maryland / Department of Health and Mental Hygiene 2001 15167 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sake 1225 AM Ma 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ohns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⋤**M 2□F Months Days Hours 212-40-5706 59 **Director** Feb. 11,1945 Mary1and Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avent, the Medical Exacilities at 10d. Inside City Limits 1 ☐ Yes ≱(XNo Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1770 Langport Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I □ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Exterminator Pest Control 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peter Sakell Eugenia Stravrolamakos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Depontment of Health and Importent: If item 27 is m any njury or other traum 2005. Renee Sakell Daughter 7401 Kenlea Ave. Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 5/8/2004 Greek Orthodox Cem. Woodlawn, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pseudomonas Priysician disease or condition resulting in death) /Medical Examiner Osteomyelitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical asthel IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by heart disease 1 ☐ Yes 2 ☐ No 3 Probably Completed Mellitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed per tension certificate 2₽No 2□ No 1 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient To 2 ER/Outpatient 3□ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To tha Funeral C 1 De/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Avenue, Baltimore, MD 21224 Subjush K. Water 4940 MI 31. Date filed (Month, Day, Year) MAY 1 2 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryla	and / Depa		lealth and M	Iental Hygi	ene g. No. 2001	
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month		3. Time of Death
	/Media	cal	CARL RICHARD 3			41.03.7		MAY	10 200	
	Examir	ier	4a. Facility Name (If not institution, give SINAL HOSPITAL OF			_	r Location of Death		4c. County of De	ath
	Funeral		5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		83 Yrs.		Hours Min.	July 5		PA
	arylar ehow	7	10a. State 10b. County	10c.	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	Maryland Carroll 10e. Street and Number		Syl	kesville 10f. Zip Code		10	g. Citizen of What C	
	3a or		911 Lee Ave.			,	1784	10	United St	
	ltems 2	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Wh	erican Indian,
Maryland 21215-0036	ours af	Ď	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates: WW		1 ☐ Yes 2 ☑ No		ritoari, 6to.)		White
15-0	s within 72 ho jiene. r than "natur the Wedical	Completed	15. Decedent's Edu (Specify only highest grad	cation e campleted)	16a. Deced	dent's Usual Occup	ation during most of worki	ng 1	6b. Kind of Business	s/industry
12	within iene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		eet Metal			Govern	ment
þ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M		in Circ
ylaı		To	William F. S	ticher			Dori	s V. Sei	da1	
Mar	and and le m		19a. Informant's Name/Relationship (T)						City or Town, State,	Zip Code)
	1 and 2 Health Iem 27 other tra		Debra Barnes da:  20a. Method of Disposition	ughter 20t	Place of Disno	Lee Ave.	Sykesvil		21784 Oc. Location - City o	r Town, State
IOE			1 ☐ Burial 2 🛣 Cremation 3 ☐ F  4 ☐ Dogation 5 ☐ Other (Specify)	Removal from State	cemetery, cren	natory or other place Services	Inc May			lle Maryland
Baltimore,	permit. Page Department i Importent: If any Injury o		21. Signature of Funeral Service Licens	1 44		ty Cremat			& Cremato	
8			Tann 1	dun		212 W. OJ	ld Liberty	Road S	ovkesville	ry, P.A.
			23a. Part   Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final					r respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a cons		AL SEPSI	S			6 HOURS
	Examiner		Sequentially list conditions	· o						
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
Y.	be be executed sician and burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
8760	ate bê d nysician he buri	icai E		d						
99	rtifical ng phy as th		IF FEMALE:							
Вох	leath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pred 1□Live birth 2□Fe	etal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
P.O.	the the	Physician/Med	1 Yes 2 No	4∐Pregnant at time o 9⊡Unknown	rdeath 5	Other (specify)				,
٠, ص	uires that the signed by detacted the detacted the detacted the detacted the detacted the sign of the	by Pr	Part II. Dther significant conditions con	ntributing to death but not r	esulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
ecords,	w require been sig should b		CORONARY ARTER	Y DISEASE				1 🗆 Yes	2 <del>2</del> № 3 □ P	robably 4 Unknown
ecc	e law re has be je 2 sh	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
	Th ate pag							performe	ed? death?	2 4 No
Vital	yeicien: is certifical director, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 Inpatient 2	☐ ER/Outpatien	Othe	26. Place of Death			Topic I a
of	Attending Physicien: r death. sctor: After this certific by the funeral director.	-4	27. Manner of Death	28a. Date of Injury (Month, Day Year)		28c. Injury	at 2	ne 5 🗆 Hesiden 18d. Describe how	ce 6 □Other (Spe	ecity)
sior	ttendin death. stor: Afr	atio	1 Natural 5 Pending 2 Accident investigation	(Worth, Day Toar)	Injury	M 1 🗀 '	Yes 2 □ No			
5	or Att after de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
_	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	(Check only 2   Medical Exami	sician: To the best of my k	nowledge, death	occurred at the tim	ne, date and place, a pinion, death occurre	nd due to the cau	se(s) and manner ase and place, and due	s stated. e to the cause(s)
	o the o the omple	Mec	one) 29b. Signature and title of certifier	and manner stated.		29c. License			d. Date signed (Moni	
	- 5 - 0		Peter W. Co	No MiD. Su	iraeon	D4	1129		AY 10, 2	
	Y		30. Name and address of person who co	empleted cause of death (It	ет 23a) (Туре, I	Print)	•			
	V		PETER W. CHO	· · · · · · · · · · · · · · · · · · ·		L OF BALT	IMORE , B	ALTIMOR	E, MARYL	AND
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2 20	32. Pagistrar's Sig		ands)				

STICHER, CARL

			Pleas		Maryland / Dep			-	•	
			1 - For State Registrar	Otate of t		ertificate of		Reg.	-2004	15169
			Decedent's Name (First, Middle,	Last)			_	2. Date of Death	Day Year	3. Time of Death
	Physici /Medio Examin	cal	MARY JOSEI  4a. Facility Name (If not institution,	the state of the s	EDY SHAFFER	4b. City, Town, o	or Location of Death	MAY 08		10:15 P M
			SAINT JOSEPH MF 5. Social Security Number	DICAL CENT	ER	TOWSON	If I lador 04 Hea		ALTIMORE	
	Funeral Director			6. Sex 7. 1 ☐ M 202+F	Age (In yrs. last birthday Yrs.	Months Days		8. Date of Birth (Month, Day, Ye	ear) C	rthplace (State or Foreign country)
			216-16-5594 Usual Residence of Decedent					May 30,	1919 M	aryland
	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show dical Examiner must be profilised at	_	10a. State 10b. County	C	10c. City, Town or L					10d. Inside City Limits
	the M	ecto	Maryland Baltime	ore County	Par	kville		10a.	Citizen of What C	
	3a or	D	8810 Walther	B1vd #33	07	· ·	1234		USA	
	death	nera	11. Marital Status	12. Was Decede			Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	
36	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-1 show aumatic event, it a Musical Examiner must be notified as	by Funeral Director	1 Never Married 2 Marrie	ed 1 Tyes 2	₹X°	1 ☐ Yes 2 ☑ No		riiodii, oto.)	0	White
5-0036	hour tural	ed b	3 NWidowed 4 □ Divorced	Year or Date	16a. Dec	edent's Usual Occur	pation	161	b. Kind of Business	
215	hin 72 9. Man "ne	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4	or 5+) (Giv.	e kind of work done  DO NOT use retire	during most of workind)	ing		•
2121	ygien ygien yar th	Con		4	Pub1:	ic Relati	ons Manage		C&P Comp	pany
and	ntal H	Be C	17. Father's Name (First, Middle, L	_				e (First, Middle, Mai	den Sumame)	
Maryland	s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. item 27 Is marked othar than "natur othar traumatic event, the Musical	은	Joseph Stepher 19a. Informant's Name/Relationsh			ling Address (Street	Elizabe and Number or Rura	eth Ann al Route Number, C	Clark ity or Town, State,	Zip Code)
	and 2		James F. Shaffer	(Step s		nger Cour	t, Henders	son, NV 8	9074	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or othar tra <u>once</u> .		20a. Method of Disposition  1 XBurial 2 Cremation	- 3 □Removal from St	20b. Place of Disp cemetery, cre	position (Name of ematory or other pla		Date 200	c. Location - City or	r Town, State
Ē	rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Sp 21. Signative of Funeral Service 1		New Catl	nedral Ce	metery 5/1	L1/2004_B	altimore,	, Maryland
Ba	Departiment Important Irraportant Irraport		Montin D. T.	remin	Į.	Mitchell	-Wiedefeld	l Funeral	Home, Ir	nc.
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau	sed the death. Do not en	6500 - Yor nter the mode of dyi	k Road Ba	altimore, or respiratory arrest,	Maryland	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		INTERSTITIA	L PNEUMOR	NIA			Onset and Death  10 DAYS
	/Medical Examiner		resulting in death)		as a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequence of):					
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с						
60,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or	as a consequence of):					
687	certificate biding physicise as the b	dicai		d						
Box	that the death certificate ed by the attending phys detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of de	alivery Day Year
0	the dea / the a	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4∐Pregnar 9☐ Unknow		Other (specify) _				
۵	s that the ned by th e detache	y Ph	Part II. Other significant condition	ns contributing to dea	th but not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobac	co use contribute t	to the cause of death?
ords	w requires that been signed to should be deta	ted t						1 🗋 Yes	21□M6 3□P	robably 4 Unknown
of Vital Records,	lawranas be	npie						24a. Was an autopsy	24b. Were a prior to death?	utopsy findings available completion of cause of
al	ician: The law certificate has bector, page 2 s			1				1₽ Yes 2□	No UTY	s 2 No
Κ	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?	Hospital:	atient 2 ER/Outpatie	ent 3 DOA Ot		n (Check only one) me 5 - Residence	e 6 ∏Other (Sp.	ecify)
٥	D a a	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of		of 28c. Inju		28d. Describe how i		,,
Siol	Attanding r death.	catic	2 Accident investig	ation		M 1	]Yes 2□No	OOA Laanting (Chron	4 m of \$1,000 to 0 m of 5	Description of the second
Division	l or At after o Direct	Certification:	4 Homicide determi	286. Place of	Injury - At home, farm, s , etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Stree City or Town, S	tand Number of H tate)	iurai Houte Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director; Al completely filled in by the fu	edicai C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the b	est of my knowledge, dea is of examination and/or i	ath occurred at the tr	me, date and place,	and due to the caus	e(s) and manner a	s stated.
	tha h thin 24 the F mplete	Medi	one)  29b. Signature and title of eartifier	and manne	r stated.		se number		Date signed (Mon	
	Z ≥ Z 8			7				Į.	5/9/04	
	20		30. If me and address of person	no completed cause	, PATHOLOGIS of death (Item 23a) (Type		3		- / / / 07	
	0	1	JAMES W. EAGAN, 31. Date filed (Month, Day, Year)	JR. M.D. 7	601 OSLER D	RIVE, TOW	SON, MARYI	AND 2120	4	
	Sta Regist	ate rar		AY 1 2 200	istrar's Signature	is April	1.0			
	, in the second			- 7	· probability of	in lake				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistrarAMEND ITEM #1 PER PHY C831 5/12/04 Rertificate of Death Reg. No. 2004 Decedent's Name (First, Middle, Last) 2. Date of Death Day SALLY, M. SKURLA Month **Physician** Year May 0840 /Medical 04,2004 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saltimore HOSPITAL topkins ion Johns If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country)
Sept. 28, 2003 Maryland **Funeral** 6. Sex Birthplace (State or Foreign
Country) Months 7 Days Hours Min. 1 ☐ M 2 🗓 F Director 218-67-7531 6 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland | Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 11109 Lamplighter Lane United States by Funeral 20854 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. College (1-4or 5+) Elementary/Secondary (0-12) None ges 1 and 2 should be filed very for Health and Mental Hygie it item 27 is marked other it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert M. Skurla, Jr. Martha Cornell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Skurla, Jr./Father 11109 Lamplighter Lane, Potomac, MD. 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 8 ate 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ott 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 2004 `4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc./ 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Livensee M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acufe Respiratory Distress
Due to (or as a consequence of): 14 Days /Medical Examiner Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of,. Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-fransit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, by SpondyloEpiphyseal Dysplasia 1 Yes 2 No 3 Probably 4 Unknown Completed Kestrictive Lung Disease 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No Division of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accider 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Che title of certifier 29b. Sign ature 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

MAY 1 2 2004

Res - 000

May 04, 2004

. Wolfe St. Baltimore, MD 21287

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See DO
32. Registrar's Signature

per on who completed cause of death (Item 23a) (Type, Print)

Mckee

			1 - For State Registrar	State		ind / Dep	artm	ent of F	Health and Death	-	Hygiei	ne _	04		517
E	Physici /Medic	cal	Decedent's Neme (First, Middle Edward Leonard     A. Fecility Name (If not institution)	Scout			l 4b C	iby Tours	or Location of De	2. Date of Month	25,	2004	Yeer	2:0	of Deat
	Examin uneral	ier	Buckingham's C 5. Social Security Number		7. Age (In yr	s. last birthday	Ada	enstor	√n ∫ If Under 24 H		f Birth	4c. County Frede	rick		ate or Fore
	mector		438-68-3066 Usuel Residence of Decedent 10a. State 10b. County	184M 2 F	-	City, Town or L				July	10,	1914	Neb	caska 10d. Inside	
with the Ma	a or 28a-f s Les nutifies	Director	Maryland Freder 10e. Street and Number 3200 Bakers Cir		Adaı	mstown		Zip Code			7.5	Citizen of W	/hat Cou		Yes 2X
5-0036 72 hours after death with the Maryland	naturel', or items 23a or 28a-f show Steal Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2(X Marital 3 Widowed 4 Divorced	12. Was De Armed	2 No 194	41-	Was De		dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes of erto Rican, etc.	r No-	14. Race	k, White		١,
within 72 ho	三瀬	Completed	15. Deceden (Specify only highe Etementary/Secondary (0·12)		(1-4or 5+)	16a. Dece (Give life.	dent's l kind of DO NO	Isual Occup work done Tuse retired	oation during most of w	vorking	16b.	Kind of Bu			
LNG Z1Z be filed with	event,	Be	17. Father's Name (First, Middle,		5+	Educa	tor			lame (First, Mic	ddle, Maid	af Edi		ion	
Maryian 2 should be and Mental	le marka aumatic	J.	Lucien Scouten  19a. Informant's Name/Relations						Edith F	Rural Route Nu	ımber, Cit		State, Zij	Code)	-
Baitimore, Maryiand 21213-0035 permit. Pages 1 and 2 should be tiled within 72 hours at Department of Health and Mental Hygiene.			Eleanor P. Scou  20a. Method of Disposition  1 □ Burial 2 🛣 Cremation  4 □ Donation 5 □ Other (S	3 Removat from	20b.	3200 Place of Disponentery, credithsbui	natory	Verne of or other plac		damstow Dete 27/2004	20c.	D 21: Location (	Ť		
permit.	Important: If any injury or once.		21. Signature of Funeral Service	Bosca		2:	2. Name	and Addre	ss of Facility K	eeney a	nd Ba	asfor	l Fu	neral	L Hom
	sician edical		23a. Pant 1. Enter the disease, or shock, by leart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Cons	caused the decear fine.	ath. Do not en Heart	er the n	node of dyin						Approxin	mate Between nd Death
be executed	hysician and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	b. Athe		cotic C	ardi	ovasc.	ular Di	sease				20 Ye	ars
. 0	ed by the attending phys detached for use as the	Physician/Medic	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pragr birth 2 Fet mant at time of nown	tal déath 3 🛭		pregnancy (specify)				23d. Date Mon		ery Day	Year
	D 90	þ	Part ff. Other significant condition  Abdominal Aorti			sulting in the u	nderiyin	g cause give	en in Part I.			use contri			
The	is certificate has been director, page 2 should	E	Type II Diabetes Renal Insufficie		S					24a. W	tas an utopsy enformed? s 2(X) N	pr	ere auto for to consath?	psy finding mpletion o	gs availab if cause o
icien:	ertifi	Be	25. Was case referred to medicat examiner?							eath (Check on	ly one)				
or Attending Physicien:	After th funeral	tion; To	1 Yes 2X No  27. Manner of Death 1 X Natural 5 Pendin 2 Accident Investic	28a. Date (Mo	Inpatient 2 of Injury of Day Year)	28b. Time of fniury		28c. Injury Work	at √ at √? Yes 2 □ No	Home 5 R	esidence be how in	6 Other	(Specif	)	
To the Hospital or Attended within 24 hours after death	To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Plac	e of Injury - At h ling, etc. (Spec	nome, farm, str			165 2 NO	28f. Location City or	n (Street a Town, Sta	and Number te)	r or Rura	l Route No	umber,
To the Hospital within 24 hours a	he Funera pletety filte	Medical C	2Ja. Cartifier (Check only one) 1 Certifyin 2 Medical (	g Physician: To the Examiner: On the and ma	e bast of my kn basis of examin oner stated.	ation and/or in	occuir estigati	on, in my op	ne, date and place pinion, death occ	ce, and due to to curred at the time	ne cause( ne, date ar	s) and man nd place, ar	ner as si nd due to	ated. the cause	9(s)
Tot		Σ	29b. Signature and title of certifier	0,0	Lin	Att	200	9c. License  D35	_		29d. D	ate signed	(Month,	Day, Year)	54
345	13		30. Name and address of person Ali J. Afrooktel		/			et, F	rederic	c, MD 2	21701				
	Stat Registra	-	31. Date filed (Month, Day, Year) MAY 1 2	2004	Registrar's Sign	dature &	أيمر	oax	:						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** PORRER IMENDOLYN 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10-1KIIn Squal 038001 0 0 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ■ M 2 💢 F 429 216.14 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10a State 10d. Inside City Limits or 28a-f show other traumatic avant, the Medical Examiner must be notified at MARYLAND 1 Yes 2 No ALTIMORE Director DALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 h and Mental Hygiene. 7 is markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) OMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IAMES AVINIA ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or othar traum QDCe. DAUGHRE RORRER BALTIMORE, MID VONNE 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State GARDANS MAY 12, 04 \* 4 ☐ Donation 5 ☐ Other (Specify) MUINOMIL 22. Name and Address of Facility 21. Signature)of Funeral Service Licens EVANS CHAPEL OF MEMORIES HARFORD RD, PARKVILLE, MD 21234 23a. Part 1. Enter the disease of complications that ca ed he death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician sastrointestinal bleeding disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Causa (Lisease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year Month 4 Pregnant at time of death 5 Other (specify) P.O. the à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Atherosclerotic Colonery Artery 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chemic renal 24a. Was an certificate has autopsy performed? Yes 2 2 No 2 No 1 ☐ Yes 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 XNo Other: 0 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Eunaral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e 56: 9-04 aux 3

Registrar DHMH 17 Rev 1/2001

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32. Registrar's Signature

Squai

Drive Bolt

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ino

1 2 2004

filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 2000 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2110 Valle DALTIMORE Timon Um
If Under 1 Year If Under 24 Hrs. Dulane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 579-02-7695 1 M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic avent, If a Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MD BALTIMORE limon um 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21093 2110 Itams 23a Valle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [V]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) nomo one maker 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental ? 0 Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784. Department of Health a Important: If itam 27 is any injury or other trainonce. Matthew )†. Date 20b. Place of Disposition (Name of cametery, crematory of other place) Newlarrollton 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State cemetery, crematory \* 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill MD EVANS FUNERAL CHAPEL -5-16-04 22. Name and Address of Facility Rd., Timonium, MB 21093
PEACEFUL ALTERNATIVES FUNERAL+CREMATION CTR 21. Signature of Funeral Service Licenses Kimber 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Coronaly artery disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 pronths? Month Day Year 5 Other (specify) Other significant conditions contributing to death by Lnot resulting in the underlying cause given in Part I. certificate has been signed 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Accident within 24 hours after death To tha Funeral Diractor: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20. If me and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mor.

Registrar

Year) 2004 2

32. Registrar's Signature

Victor Ramone Siri-Ramos Unknown 04-165 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. 04-03109 State of Maryland / Department of Health and Mental Hygiene UU4 1 - State Registrar cm Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Year **Physician** P Victor Ramone Siri⊸Ramos 07 2004 6:59 /Medical May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly
Year | If Under 24 Hrs. Prince George's 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** XIXM 2□F 57 Months Days Hours Min. Director none 1946Dominican Ren Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits or than "natural", or frems 23e or 28e-f show the Medical Examiner must be notified at 1 XYes 2 □ No New York New York New York Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 506 West 173 rd. Street 10032 Dominican Republic Pages 1 and 2 should be filed within 72 hours after death 1 bent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Dominican Baltimore, Maryland 21215-0036 ty⊡Yes 2□ No þ Specify: Dominican 3 ☐ Widowed 4 ☐ Divorced Republic Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pedro Jose Siri 2 Maria Esperanza Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tree once. 506 W. 173rd Street #2C N.Y. N.Y. 10032 Rafael Siri Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State Municipal Cemetery 5/13/04 Santiago. 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4425 Broadway N.Y. Mo1113 R.G. Ortiz Funeral 10040 Home 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequent of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ρ No No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy leath? Yes certificate 2□ No Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Clieck only one) examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 6 ☐Other (Specify) 28a. Dat, of In ury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Hospitel or Attending 1 Natural 5 Pending 04 8 1 ☐ Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide Flace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. or Rural Route Number, 4 Chomicide 03 within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causals alternated at the time, date and place, and manner stated. 29a. Certifier Medical (Check only one 29d. Date signed (Month, Day, Year) O.C.M.E. May 08, 2004 30. Name and address of person who eted cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 J. Laron Locke M.D.

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAY 1 2 2004

32/Registrar's Signature

04-03117 John Smith RJD

D	SHILLII		1- For Unpend Item #23a,pt.II,27 per me.G83	t of Health and Me 2 6/2/04 tas e of Death	ental Hygier	ne vo.2014	15175
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  John Smith		. Date of Death	2004 Year	3. Time of Death 0612A . M
0	Exami		Maryland General Hospital Bal	Town, or Location of Death	4	4c. County of Death	<del></del>
26	Funeral Director		5. Social Security Number  2/4-4/0-9438  6. Sex 1 DPM 2 F  7. Age (In yrs. last birthday) Months  Usual Residence of Decedent	Davs Hours Min.	Date of Birth (Month, Day, Yea January 24,	9. Birthp Cour	place (State or Foreign htty)
	e Maryland 8e-f show	Director	10a. State 10b. County 10c. City, Town or Location Baltimor	e		1	0d. Inside City Limits 1 ■Yes 2 □ No
	filed within 72 hours after death with the Maryland Hygiene. In the rhen "naturel", or Items 23e or 28e-f show ent, the Medical Evaninar must be rediffed at	Funeral Dire	106. Street and Number  903 Pennsylvania Avenue - Apt. 2A  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. If Yes, specify Yes, specify Yes, specify Yes, specify Yes, specify Yes, specify Yes, specify Yes, specific Yes, yes, yes, yes, yes, yes, yes, yes, y	Code  Z / Z O /  Jent of Hispanic Drigin? (Specificity Cuban, Mexican, Puerto Ric		OSA  14. Race - Americ	ean Indian,
-0036	hours after turel', or Ite	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify:		Specify: B	ack
Maryland 21215-0036	filed within 72 Hygiene. kther then "naf	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT us	K done during most of working	16b.	Kind of Business/Inc	•
Vland	12 should be filed h and Mental Hyg 7 is marked othe treumatic event,	To Be C	17. Father's Name (First, Middle, Last) John E. Smith, Sir,		ene :	on Sumame) Sm,Hj	
	of Heal of Heal if item 2		20a. Method of Disposition (Name of Disposition) (Name of Disposit	ther place)	- St. 2	Baltimony Location - City or To	MD 21205
Baltimore,	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licensee  22. Name and  23. Signature of Funeral Service Licensee	Cem. 5-15 Address of Facility Tessier St	Euneral B	Semuito	P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardio Due to (or as a consequence of):	e of dying, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
.O. Box 6	that the death certific ed by the attending p detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre			23d. Date of deliver Month	ry Day Year
ords, P	w requires that been signed b should be deta	ed by Pr	Part II. Dther significent conditions contributing to death but not resulting in the underlying ca  Chronic Alcoholism	use given in Part I.	23e. Did tobacco	use contribute to the	~
Vital Records, P.O.	i <b>cien</b> : The law racecertificate has be				24a. Was an autopsy performed? 1 Yes 2 □ N	prior to com death?	osy findings available apletion of cause of
Division of Vit	ding Phys n. After this funeral di	Certification; To Be	2 Accident investigation M	3c. Injury at Work? 1 Yes 2 No	5 ☐ Residence . Describe how inju		
Div	To the Hospitel or Attend within 24 hours after death To the Funeret Director: completely filled in by the		28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)  29a. Certifier  1 Certifying Physicien: To the best of my knowledge, death occurred a	t the time, date and place, and	due to the cause(s	s) and manner as sta	nted
	To the Ho within 24 To the Fu	Medical		in my opinion, death occurred a	29d. Da	ate signed (Month, D y 09, 2004	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11	1 Penn Street,			
200	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2 2004  Agents Signature			-	

Alan H. Seidman Unpend Item#231,28a-f, PR ME (831,5/27/V) Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03146 DOS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month ALAN HOWARD SEIDMAN 9, May 2004 938 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7913 Brookhaven Road Windsor Mill Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Min. 213-64-3417 44 Yrs Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event. The Medical Examiner must be nutified at Director 1 ☐ Yes 2 ☐ No BALTIMORE WINDSOR MILL 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 238 7913 BROOKHAVEN ROAD 21244 Completed by Funeral U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) UNITED HOME SAVINGS - BROKER MGT. BROKER CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ! ARTHUR SEIDMAN SHEILA 0 ANSELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 SHEILA SEIDMAN / MOTHER 7913 BROOKHAVEN ROAD - WINDSOR MILL, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit, Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MOSES MONTEFIORE CEM. 5/11/2004 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Awans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Methadone Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last nding physician and Due to (or as a consequence of) Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Obesity 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗆 No 1□ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only ode) examiner' Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA at scene 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 🙀No investigation 2 Accident unknown after death unknown 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in home 791.3 Brookhaven Rd., Windsor Mill., MD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) OCME May 10, 2004 Ray pendel ass of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MU Feni ock 2

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MAY 1 1 2004

32. Registrar's Signature

			_	For State Registrar	State of Ma	ryland		artment of Hortificate of L			Reg. No.	2004	15177
	Ph	ysicia	n	Decedent's Name (First, Middle,     SIGMUND I	Last)		SA	CHS		2. Date of De.	ath Day	Year 2004	3. Time of Death 22 15 PM
	>	ledica amine	a! -	4a. Facility Name (If not institution,	give street and number)		Jr	4b. City, Town, or	Location of Death	1 ay		county of Death	
	^	airiirie	,	Singi Hospita	1 of Balt	imo	re		nore Ci	٢,		N/A	
	Fun	_	- 1	5. Social Security Number 6	. Sex 7. Age 1,□ M 2□ F		ast birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Date of Birl (Month, Da	th y, Year)	9. Birthr	place (State or Foreign htry)
75	Dire	ctor		220-12-6133 Usual Residence of Decedent	X	78	3			08/24/	1925		MD
ac	Maryland -f show	iii	_	10a. State 10b. County			, Town or L						0d. Inside City Limits 1 ☐ Yes 🕹 ☐ No
V	the Ma	all la	Funeral Director	MD N	/A	BALT	TIMORE	10f. Zip Code			10a Citiza	en of What Cou	^
1-1	death with the ma 23a or 28a	Tes.		3601 FORDS LANE	#511			21215				S.A.	, .
- Pu	death	E I	nera	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No Rican, etc.)		Race · Americ Black, White,	
3	36 s after , or Ite	amira	by Fu	1 Never Married 2 Marrie		lo		1 ☐ Yes 2 ☐ XNo	Specify:	, , , , ,			ITE
Sigmon	5-003 72 hours natural',	CalEx	ed b	15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ation		16b. Kind	d of Business/In	dustry
	.1215 within 73 ene. then "na	Med	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	+)		kind of work done d DO NOT use retired)	furing most of work )	ing			
	d 21 filed wi Hygien ther th	4		12 17. Father's Name (First, Middle, La	net)		OWNE	R	18. Mother's Nam	a /First Middle		SPORTAT	ION
Š	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show	ic eva	To Be	WILLIAM	131/		SACH	S	ROSE	0 (1 // 31, 19/100/0,	mandon o		DMAN
Ž.	ary shou and M	эптар		19a. Informant's Name/Relationshi	o (Type, Print)			ng Address (Street a		al Route Numbe	er, City or		
	and and sealth m 27	har tre		· · · · · · · · · · · · · · · · · · ·	WIFE	20h 9i		FORDS LA		BALTIM		D. 2121	
Patient	Baltimore, bermit. Pages 1 a Department of Hez mportent: If Item	or of		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3		MD %	TETERA	NS CEMETE	₽v			ation - City or To	
7	Iltin	injury B.		*4 □ Donation 5 □ Other (Special Signature of Fun ra Service Li			2	2. Name and Addres		0/2004 LEVING			
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	760, te be ex ysician	2	caj E		335 15 (6) 25	2 00110040	201100 017.						
					- u.								
	I Records, P.O. Box 68  The law requires that the death certifice are has been signed by the attending ph	ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)			23	d. Date of delive Month	ery Day Year
	s that I	be detached t	by Ph	Part II. Other significant condition	s contributing to death be	ut not resu	ulting in the	underlying cause give	en in Part I.	23e. Did t	obacco us	e contribute to t	he cause of death?
11	ecords, law requires ti	should b	ted t	Corenary Arte	ry Disease	, Atr	ial Fi	brillatic.	<del></del>	10,	Yes 2 🔽	No 3□Prot	pably 4 □Unknown
Y	al Reco	page 2	Completed	Diabetes, Ch	nonic Rex	1	lhaus	ficienc	<del>/</del>	24a. Was autor perfo 1 \( \text{Yes} \)		prior to co death?	psy findings available impletion of cause of
	Vita sician certifi	recto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		ER/Outpatie	nt 3 DOA Othe	26. Place of Deat er: 4 ☐ Nursing Ho			Other (Seesi	(4)
	O f =		$\vdash$	27. Manner of Death	28a. Date of Injur	ry	28b. Time	The same of the same of		28d. Describe			y/
	Sior tendin eath. or: Af	the fur	catic	1 Matural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	ation			M 1 🗆 Y	Yes 2□No	201 1 1 1 1 1	a		10
	Division tal or Attendit s after death.	d in by	Certification;	4 Homicide determin				reet, factory, office		City or To	wn, State)	Number or Hur	al Route Number,
	Hospil 24 hour Funere	Metely filled	ledicai C	29a. Certifier (Check only one)  1 Certifying 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examinal	wledge, dea tion and/or i	th occurred at the time investigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) a date and p	ind manner as s blace, and due to	tated. o the cause(s)
	To the within 2	сош	M	29b. Signature and title of certifier	/			29c. License			29d. Date	signed (Month,	
		11		1/2/	Jung	MC			5-000	)	May	1/ 20	04
		1.		30. Name and address of person w	mg completed cause of d	eath (Item	11	ited of	Balt	meins	-		
	Re	Sta egistra		31. Date filed (Month, Day, Year)	04 3. Registra	ar's Signa	-	Sports	1   1				

			For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	artment of H			ene g. No. 200	4 15178
· ,	45		Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physicia		JULIA	VIRGINIA	TAI	ODE		Month May 7,	2004 Year	3100 A.M
	/Medic		4a. Facility Name (If not institution,				r Location of Death		4c. County of Dea	th
			C. J. Senio	r Care		Hagers	stown		Washi	ngton
<u> </u>	Funeral			6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
o. Ži	Director .		233-03-1659	1□M 20XF	100 Yrs.			December	3, 1903 W	West Virginia
pu	<b>x</b> .3		Usual Residence of Decedent  10a. State 10b. County		10c. City. Town or Lo	cation				10d. Inside City Limits
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he N	28a-f	Directo	Maryland Wash  10e. Street and Number	nington	Hagers	10f. Zip Code		10	g. Citizen of What Co	ountry?
with	23e or 28e-f show	급		4						
eath	ns 23	Funeral	145 King Str	12. Was Decedent I	Ever in U.S. 13. \	2174( Was Decedent of H	U Iispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	U.S.A 14. Race - Ame	
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hours after death with the Maryland	al', or	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: W	nite
72 hours	natural' ical Ex	Completed	15. Decedent' (Specify only highest	s Education	16a. Deced	lent's Usual Occup	nation during most of work d)	ring 1	6b. Kind of Business	/Industry
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y lo	Men	၉	Walter		Charnoc		Mati			lville
Natyland d 2 should be file	ls m		19a. Informant's Name/Relationsh						City or Town, State,	
	Health and Notes that the traumal		Eve J. McGro	ry Friend	121 /	Linds	ay Lane,	Hagers	town, Ms Oc. Location - City or	ryland 217
Pages 1	0 = =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	cemetery, cren	natory or other plac	ce)			
Pa	tant: jury		*4 □Donation 5 □ Other (Sp		Smithsbur		orium US	-08-043r	mithsburg,	Maryland
Daillinore, permit. Pages 1 a	Department Important: I any injury o		21. Signature of Funeral Service L	icensee	Ąn	Name and Addre	Soffman F	uneral Ho	ome, Inc. Jerstown,	
			K. Mee	scany-	40	East Ant	tietam St	reet, Hac	jerstown,	Md. 21740 Approximate
			23a. Part1. Enter the disease, or shock, or heart failure. List of	only one cause on each lin						Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition resulting in death)	_a. A(V)	TI: 14700	ARDIA	L MAG	4 RCT10	X	5 MINUTE
	Medical xaminer		resulting in dealing	Due to (or as	a consequence of):	1.00	co As we	esene A w	non-nave	10 1/04 1
		_	Sequentially list conditions,	b. Due to (or as	a consequence of):	20116	COROWA	KYAA	1114	10 YEARS
bet	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					11/1/	1/65/2	
, axecu	al-tra	xai	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
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ificat o	g phy as the	Physiclan/Medical		J						
The law requires that the death certifical	attending p	\ <u>\</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy	,		23d. Date of de	
deat a	e atte	icla	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at		Other (specify)	, 		Month	Day Year
. a	by the a	hys	9 Unknown	9∐ Unknown				-		
S tha	signed l	<b>by</b> P	Part II. Dther significant conditio	ns contributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
	been sig							1 🗆 Yes	s 2 ⊡1¶o 3 □ P	robably 4 Unknown
Hecords,	s be	plet						24a. Was an autopsy		utopsy findings available completion of cause of
T ed	ite has	Completed						perform		
		BeC	25. Was case referred to edical				26. Place of Dea	th (Check only one		Assisted
	iis ce direc	TOE	examiner? 1 ☐ Yesy 2 ☐ No	Hospital:	ent 2 ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	ome 5 Resider	nce 6 10 Other (Spe	ecity) Living
ָר פַּ	h. After thi funeral		27. Mann of Death  1 → atural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time of Injury	28c. Injur War	ry at	28d. Describe hov	w injury occurred	
o a		atlc	2 Accident investig	ation			Yes 2□No			
DIVISION OF	after deat Director: In by the	tific	3 Suicide 6 Could n 4 Homicide determi	ned 288. Place of Int	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
الم الم	rs aft rai Di	Certification:								
1080	4 hours unaral	cal	(Check only 2 Medical I	g Physician: To the best Examiner: On the basis o	f examination and/or in					
To the Hospital or	within 24 hours after of To tha Funaral Direct completely filled in by	Medical	one)	and manner sta	ated.	29c. Licens			d. Date signed (Mon	
Ę	N CO	-	29b. Signature and title of certifier	MN DED mi	VAI DING	10 AAI	0	2/10:-	/// \	-7 A - 1 -
	2		Voled Smill	(II) VERSOU	into Lass	ICARIY	N 000	14359	(MM)	1 2004
	0		30. Name and address of person	who completed cause of d	leath (Item 23a) (Type,	Print)	7 111/	100000	IN INI	2/2/10
9,57			31. Date filed (Month, Day, Year)	22. Registr	ar's Signature	1000 31	. (4/16	ERSTOL	UCK, ("(L)	21/1/
	Sta Regist			004	. B. Son	Les of the second				

			1 - For State Registrar	State of	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2							000	11.	15170	
	Physic	an	Decedent's Name (First, Middle, Last)										Date of Death		3. Time of Death
	/Medi		Davida G. Task							May		, 20	6ar 0 4	10:30a M	
	Exami	ner	4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death					4c. County of Death		
			Hebrew Home of Greater Washington  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			Rockville If Under 1 Year   If Under 24 Hrs.   8 Da					Montgomery				
	Funeral Director		002-22-2681	1 M 2 T	98	Yrs.	Months [	Hours	Min.	8. Date of ( (Month, May 4	Day, Year	)	Cour		
		1	Usual Residence of Decedent					1			Hay 4	, 130	1906   New York		IOLK
	irylan show	Director	10a. State 10b. County		10c. City, Tow	n or Lo	cation							1	0d. Inside City Limits
	Ba-f s			gomery	Rockv	ill	е								1, Yes 2 No
	ith th	Dire	10e. Street and Number				10f. Zip Co	10f. Zip Code 10g.					itizen of Wh	at Cour	itry?
21215-0036	s 23s	Lai	6121 Montrose R			1	20852					L	USA		
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23a or 28a-f show other treumatic event, the Madical Exams at must be rediiled at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed For		13. \	Vas Deceden f Yes, specify	t of His Cuban	panic Ori n, Mexicar	gin? (Spo 1, Puerto	ecify Yes or i Rican, etc.)	No-	14. Race - Black,	Americ White,	
		by	3XXWidowed 4 □ Divorced	If Yes, Give	9		I□Yes 2X	ΧNο	Specify:				Specify:	Wh	ite
			15. Decedent	's Education	16a	. Deced	lent's Usual (	Occupa	tion			16b. ł	Cind of Busin	ness/Ind	dustry
21		Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L	kind of work of DO NOT use	done du retired)	iring mos	t of work	ing				,
		ပ္ပ	Grade 12	4 Years		Leg	al Sec	ret	ary			C]	lerica	1	
<u>n</u>		Be	17. Father's Name (First, Middle,	Last)							First, Midd	lle, Maidei	n Sumame)		
3		1º	Jacob Green							Lov					
Maryland			19a. Informant's Name/Relations Ted Task /	son			g Address (S King F								
	Health tem 27		20a. Method of Disposition	5011	20b. Place o	f Dispo	sition (Name	of	1		Rockvi		.ocation - Cit	085	
JO L	ages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)				natory or othe Burial			Mav -	LO,200				, N.J.
Baltimore,	permit. Pages Depertment of the timportent: If ite any injury or of once.		21. Signature of Funegal Service												,
	Per Imp Per Imp		21. Signature of Funeral Service Licensee  Berschler & Shenberg Funeral Chapels 5341 State H. 38 West Pennsauken, N.J. 08109												
E	6 H		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition condition and Death)  CEREBRAL THROMBOSIS												
	Medical Examiner														
			resulting in death)  Due to (or as a consequence of):												
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury												
	xecui and al-trar	Examin	that initiated events resulting in death) Last	c. Due to (o	r as a consequence	of):								-	
68760,	ficate be executed physician and is the burial-transit			l i		ľ									
687	- C0 41	edicai		d											
Вох	eath certif attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							23d. Date of delive			rv		
	es that the d gned by the be detached	sicia	in the past 12 pronths?	4□Pregna	th 2 Fetal death nt at time of death		Ectopic pregr Other (speci						Month		Day Year
P.0		hys	9 ☐ Unknowh	9LJ Unknov											
of Vital Records, F		by									cco use contribute to the cause of death?				
	w requir been si should	Completed	HYPERTENSION 1-Yes							Yes 2	2 No 3 Probably 4 Unknown				
ec	elaw hasb	npie									24a. We	s an	24b. Wer	e autop	sy findings available
<u>E</u>		S									per 1 ☐ Yes	formed?	dea		
Vit	Physicien: this certificaral director, p	Be	25. Was case referred to medical examiner?	Hospital:					-	of Death	(Check only	/ оле)			
Division of \	ys dil	T:	1 Yes 2 No 27. Manner of Death	28a. Date of	patient 2 ER/Ou		3□ DOA Other: Nursing Home 5□ Residence 6 □ Other (Sp					Specify	)		
	ding Ph h. After th funeral	tion	Natural 5 ☐ Pending	(Month		Time of njury	M 28c.	Work?	at es 2.⊟h		28a. Describe	a now inju	ry occurred		
	i or Attending after death. Director: Afte in by the fune	ertification:	& Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre								28f. Location (Street and Number or Rural Route Number,				
Ö	ei or A s after ii Dire	Cert	4 ☐ Homicide determined building, etc. (Specify)						City or Town, State)						
	e Hospitei o 24 hours al e Funerai D etely filled i		29a. Certifier Certifyin	Physician: To the b	est of my knowledge	, death	occurred at t	he time	, date and	d place, a	and due to th	e cause(s)	) and manne	er as sta	ated.
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	one)	xaminer: On the bas and manne	sis of examination an er stated.	d/or inv	estigation, in	my opir	nion, deat	h occurre	ed at the time	e, date and	d place, and	due to	the cause(s)
	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier	21-11			29c. Li	cense	number	C	(1	29d. Da	te signed (M	fonth, D	Day, Year)
•	(		MIKE	sort Mi	D .		<i>'</i> )	/	80	8	7	MA	407	12	004
	V		30. Name and address of person v	who completed cause	of death (Item 23a) (	Туре -	Print)	1 -	1-	) e 2 E	2	10	)	11.	Nay, Year) 004 MD20822
			31 Batter/Hatt Worth Bon Noort	A TEL	m D ==	p	121 /	10	N 11.	res	2 12	4) /	eckv	ui,	MUZVOSZ
	Sta Registr		31. MAY 102. 2004"	Jan Co	gistrar's Signature	200	es								

DAVIDA TASK

			For State Registrar	State of M	laryland	d / Depa		Health a	and Mer	ntal Hygie	200		
			Decedent's Name (First, Middle, Last)							Date of Death	Death 3. Time of Death		
	Physicia		Edna	Brown			Turner			Month .y 1, 20	Day Year	12:35 PM	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)				4b. City, Town	, or Location o		y 1, 20	ath		
	Funeral Director	•	Bradford Oaks	Nursing Hom	e		Clinto	n			Prince George's		
			5. Social Security Number 223–22–0997	+		ast birthday) Yrs.	If Under 1 Yea Months Day		Min.	Date of Birth (Month, Day, Y	9. B	irthplace (State or Foreign Country) 'irginia	
3	0		Usual Residence of Decedent  10a. State 10b. County	1		, Town or Lo	cation			,	1313	10d. Inside City Limits	
	fsho	ō	Maryland Calv	ort	C+	Leona	and .					1 ☐ Yes 2X No	
-	289	Funeral Director	Maryland Calv  10e. Street and Number		SC.	Leona	10f. Zip Code			100	. Citizen of What (	Country?	
3	perint. Tages I and a Stoom of med which it index are local with the maryane perint. Tages I and the stoom of	Ö	5637 Cherry St	reet			207				U.S.A.	,	
		era	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V	Was Decedent of f Yes, specify Cu		gin? (Specify	Yes or No-		nerican Indian,	
9	or Ite	Ē	Armed Forces?  1 Never Married 2 Married 1 Yes 2 M No						, Puerto Rica	an, etc.)			
3	iral.	d by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:				1□Yes 2ሺN	o Specify:			Specify: White		
ה ה	natu dica	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	dent's Usual Occ kind of work don	e durina most	t of working	16	b. Kind of Busines	s/Industry	
7	han han	mpi	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)								0 11		
V :	Hygie ther t		12 Homemaker							ret Middle Ma	Own Home		
	ntal h	Be	17. Father's Name (First, Middle, Last)  Lee Brown  18. Mother's Name (First, Middle, I  Mary Belle Brown							•			
<u> </u>	mark matic	ဥ	19a. Informant's Name/Relations	shin (Tyne Print)		19h Mailir	no Address (Stra				ity or Town, State, Zip Code)		
2 3	th and the strain trains		Joseph Gary T				Weish R					21p C00e)	
ָּע ע	Heal Heal tem 3		20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,			sition (Name of natory or other p		Date		c. Location - City of	r Town, State	
	ages ant of t: If i		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5				natory or other p Cist Chu		/5/04		ignum, V		
	artm ortar injur		21. Signature of Funeral Service		Buc	22	Name and Add	ross of Facility					
Ď	Depa Impo any it		Dennie	Willm	m-	-   0	lore En	glish i	Funera	1 Home	lpeper,	VΔ 22701	
			23a. Part1. Enter the disease, o	r complications that cause	d the death	. Do not ent	er the mode of d	ying, such as	cardiac or re	spiratory arrest	ререг	Approximate	
,	Thystolan: The taw requires that the dearth certificate be executed to the serificate has been signed by the attending physician and the point of the control of the contro		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):  Seguentially list conditions,								Interval Between Onset and Death		
										grani			
Ļ				1				CKAU					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):	, , , , , , ,					0			
		Examin	Cause (Disease or injury that initiated events c.										
,00	ian a urial-	Ä	resulting in death) Last	Due to (or as	s a cons <i>e</i> qu	ence of):							
0	sate p shysic the b	dicai		d									
O :	ding p	/Me	IF FEMALE:	22a Huga sutasm									
2	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Federal death 3 Ectopic pregnancy							23d. Date of de Month	eliv <i>er</i> y Day Year		
5	w requires that the death certifies been signed by the attending pt should be detached for use as the	Physician/Med	1 □ Yes 2 □XNo 9 □ Unknown	9□ Unknown	it time or de	atn 5	Otner (specify)			· · · · · ·			
Ĺ	ed by detail		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobac	tobacco use contribute to the cause of death?		
Spio	ngis r Id be	d by	Now H	NOW Hodakhil lymphones 1 - Yes						No 3 Probably 4 Unknown			
5	w red beer shou	lete	24a Wasan						24a. Was an	24b. Were autopsy findings available			
ב ב	ne la e has age 2	Completed								autopsy performed	prior to death?	completion of cause of	
ב ב	ifficat or, p	ပိ	25. Was case referred to medica	1				OS Blace	of Dooth (C)	1□Yes 2页	(No 1 □ Ye	s 2 No	
5	s cert	o B	examiner?								es C DObbes (Conside)		
		n; T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at							28d. Describe how injury occurred			
5		atio	1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest	Work? M 1 ☐ Yes 2 ☐ No									
2	er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Lo							f. Location (Street and Number or Rural Route Number, City or Town, State)			
5	rs after or rs after or rafter or ra	Cer											
	tne Hospital of Attending hin 24 hours after death. the Funeral Director: Afte npletely filled in by the fune	edicai	29a. Certifier 1 X Certifyi (Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis of and manner si	of examinat.	vledge, death ion and/or inv	occurred at the vestigation, in my	time, date and opinion, deat	d place, and th occurred a	due to the caus t the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)	
	within To the	Me	29b. Signature and title of certific	I L			29c. Lice	nse number		29d.	Date signed (Mon	ith, Dey, Year)	
) '	7 0		) //	7				1194	71		5/2/0	4	
			30. Name and address of person	who completed cause of	death (Item	23а) (Туре,	Print)	<i>y</i> ' '			- 1010		
			Trank Mike	Du mo 1100	14	VINGST	W/4	#103	TT. W	14shtug	Do Mi	20144	
	Sta Registr		31. Date filed (Month, Day, Year	82. Regist	rar's Signat	иге	E)			J		-	

The part of the			-	For Steta Registrer	State of Ma	aryland		artment tificate			and M		giene , Reg. No. <sup>(</sup>	2004	151	81
The composition of the compositi		Physicia			, Last)							Month				
The property of the property o		/Medic	al		in about and number			4h Cihi I			of Dooth	May				Pin
Second Second Number   Second Second Second Number   Second Second Number   Second Second Number   Second	<b>,</b>	Examin	er	An Hacility Name (IT not institution	Savive street and number)	inal Ce	nter	4b. City,	$\mathcal{B}_{n}$	11 '			40. 0			
Provided   Part   Par		Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. las	t birthday)			If Under	24 Hrs.	8. Date of Birt	th Voar	9. Birti	place (State or	Foreign
Top State   100 County   100 City Power of Location   100 Typ Code   100 Typ Co				237-34-0173	1 <b>X</b> M 2□ F	80	Yrs.	Months	Days	Hours	MIN.	May 16	, 1923	NC.	unury)	
Ceraldine Thomas  Wife 7753 Charlesmont Road, Dundalk, MD. 21222  Date 200 Steep of Deposition of De	pug	<b>3</b> ::				10c. City. 1	Town or Lo	cation		-					10d. Inside City	y Limits
Ceraldine Thomas  Wife 7753 Charlesmont Road, Dundalk, MD. 21222  Date 200 Steep of Deposition of De	Manyla	f sho	ö	- 7	more										1 🗆 Yes	2 <b>∏</b> No
Ceraldine Thomas  Wife 7753 Charlesmont Road, Dundalk, MD. 21222  Date 200 Steep of Deposition of De	the !	7.28e-	rect		OIC				Code				10g. Citiz	en of What Co	untry?	
We can all a large to the second programs of	th with	23a o	al D	7753 Charlesmon	t Road				212	22			US	SA		
We can all a large to the second programs of	r deal	ems er m	ner	11. Marital Status	Armed Forces?	,	13. \	Was Deced f Yes, spec	ent of Hi	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 1			
We can all a large to the second programs of	<b>36</b> 's afte	, or it	y F		If Yes, Give	No		1□Yes 2	<b>N</b> No	Specify:				Specify: Wh:	ite	
We can all a large to the second programs of	-00 Y	atural	ted t	15. Decedent	's Education		16a. Deced	dent's Usua	J Occupa	ition			16b. Kin	d of Business/	Industry	
We can all a large to the second programs of	215 Pin 73	an "n	ple			5+)	life.	kind of wor DO NOT us	k done d e retired,	<i>luring</i> mos )	t of work	ing				
We can all a large to the second programs of	21 pg	ygiene ver thi t, I've	Con	6 years			Cran	e Ope	rato			10° 1 4 4 4 4			Steel	
We can all a large to the second programs of	and be fil	even	Be		Last)		}						maiden s	oumame)		
Ceraldine Thomas  Wife 7753 Charlesmont Road, Dundalk, MD. 21222  Date 200 Steep of Deposition of De	L A	nark mark metic	유		nip (Type, Print)		19b. Mailir	ng Address	(Street a				er, City or	Town, State, Z	ip Code)	
Pitysision Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examine	Ma Mass	27 is r trau	f : ]			_		-								
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Pitysision Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examiner  Pitysis Medical Examine	Page	ant: If									IAy 1	4,2004	Bela	ir, MD.		
Plays Use Immediate Classe (Final failure List only one cause on each line.    Medical Examiner	Balt Permit.	Departr Imports any inj		21. Signature of Funeral Service	Licensee	7	7	onnel 1110 S	1y F olle	unera ers Po	al Ho	ome Of I Road, I	Dunda Dunda	lk,P.A lk,Md.	21222	
Private   Priv				23a. Parti. Eiter the disease, or shock, or heart failure. List	complications that ause only one cause on each l	d the death. ine.	Do not ent	er the mode	e of dying	g, such as	cardiac	or respiratory a	rrest,		Interval Betw	veen
Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate water tresulting in clearly Last for a same consequence of):			0.1	disease or condition	a. Pneu	monie	FA.									
The policy of th				resulting in death)	Due to (or as	a conseque	nce of):									
Gusse. Enter Underlying aguse. Enter Underlying agus. Enter Underlyi	1		ē.	Sequentially list conditions, if any, leading to immediate		a conseque	nce of):									
Section   Sect	nted	dansit	m L	Cause (Disease of injury	6									-		
FEMALE:   23b. Was deedednt pregnant in the past 12 months?   1   1   ve s   2   No   1     1     1     1	O,	an an	Exa	resulting in death) Last		a conseque	nce of):	•••								
FEMALE:   23d. Date of delivery   23d. Date of deliv	876	hysici the bu			d								·			
State   Stat	× 6	ding p	/Mec		23c. If yes, outcome	e of pregnance	ev						2	3d Date of deli	very	
State   Stat	Bo	atten I for us	cian	in the past 12 months?	1 ☐ Live birth	2 Fetal d	eath 3						-			ear
1   Yes 2   Mo 3   Probably 4   Unix   Proba		by the achec	hysi		9□ Unknown											
24a. Was an autopsy findings averaged to medical examiner?    1		gned l		Part II. Other significant condition	ons contributing to death t	but not resulti	ing in the u	nderlying c	ause give	en in Part I	l.					
Total   Part	ord	en sig										10'	Yes 21	iNo 3∏Pr	obably 4 UU	nknown
26. Place of Death (Check only one)  27. Manner of Death 1	ec.	has be	nple									auto	osy	prior to d	topsy findings a completion of ca	ivailable luse of
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury 28b. Time of 1   Yes 2   No  28b. Time of 1   Yes 2   No  28c. Injury at 28d. Describe how injury occurred  28d. Describe how injury occu	_	parte										1 ☐ Yes	2 No	1 🗆 Yes	2 No	
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury 28b. Time of 1 nivestigation 3   Suicide 4   Homicide  28a. Date of Injury 28b. Time of 1 nivestigation 3   Suicide 4   Homicide  28a. Date of Injury 28b. Time of 1 nivestigation 3   Suicide 4   Homicide  28a. Date of Injury 28b. Time of 1 nivestigation 3   Suicide 4   Homicide  28b. Time of 1 nivestigation 3   Suicide 4   Homicide  28c. Injury at Work? 1   Yes 2   No  28f. Location (Street and Number or Rural Route Number City or Town, State)  28d. Describe how injury occurred  28d	Vit	certif		examiner?	Hospital:	iont 2 TF	P/Outnaties	nt 3 🗆 DC	Othe					□Other /Sne/	cifu)	
The state of the s		ra H		27. Manner of Death	28a. Date of Inj	ury 2	8b. Time o	_	-							
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	ion	ath. or: Aft	atlo	2 Accident investi	gation	19 7007)	rijury				No					
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)		E	rifle	dotor	ined 286. Place of In		ne, farm, sti	reet, factory	, office			28f. Location ( City or To	Street and wn, State)	Number or Ru	iral Route Numb	oer,
Support Brown, M. D., Ph. D.  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lynette Brown, Johns Hepkins Hospital, 600 North Wolfe, Beltimore, Mn 21287		eral D		202 Cartifier 4 Towissis	on Physician: To the best	t of my knowl	ladge doct	h occurred	at the +i-	ne date or	nd place	and due to the	cause(s)	and manner on	stated	
Support Brown, M. D., Ph. D.  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lynette Brown, Johns Hepkins Hospital, 600 North Wolfe, Beltimore, Mn 21287	HOR	24 hc e Funi	dica	(Check only 2 Medical	Exeminer: On the basis of	of examinatio										
Support Brown, M. D., Ph. D.  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lynette Brown, Johns Hepkins Hospital, 600 North Wolfe, Beltimore, Mn 21287	Toth	within To the compl	Me													
Lynette Brown, Johns Hopkins Hospital, 600 North Wolfe, Beltimore, Mn 21287		'n		Grette Bear	on M.D., Ph.	. Д.			2 65 -	000	•		may	11,20	94	
31 Date filed (Month Day Year) 32 Begistrar's Signature		Ü	)												2.4.00	3
SIETE OI, Date more province only, 1 only							re					e . Ba	Itimo	re, Mn	21287	<u> </u>
Registrar MAY 1 2 2004 Denus & Sparks						_	6	So	ak	1	Ĭ					

State Registrar ANA

MAY 1 2 2004

31. Date filed (Month, Day, Year)

RUBIO

MD

82. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			_ For	State of Man	yland / Depa	artment of I	Health and M	lental Hygi	ene			
			1 - State Registrar		Ce	rtificate of	Death		g. No. 200			
,	Physici /Medic		1. Decedent's Name <i>(First, Middle, L</i> June	E.		Urbanek		2. Date of Death Month May 4, 2	Day Yeer	3. Time of Death 7:30 PM		
	Examir	ner	4a. Facility Name (If not institution, g				or Location of Death		4c. County of Dee			
			3110 Myrtle Ave		In yrs. last birthday)	Temple		8 Date of Birth	Prince G	eorge's thplace (State or Foreign		
L	Funeral Director		57.9-20-0576 Usual Residence of Decedent	1 □ M 2√2√F	80 Yrs.	Months Days		8. Date of Birth (Month, Day, 12/23/19	Vear) C V23 Was	hington, DC		
	yland		10a. State 10b. County	1/	Oc. City, Town or Lo	ocation				10d. Inside City Limits		
	a-1-s	ctor	Maryland Prince	George's	Temple	Hills				1 □ Yes 2⁄□XNo		
	er 28	Oire	10e. Street and Number			10f. Zip Code	7.1.0	10	g. Citizen of What C	ountry?		
	s 23a	rai	3110 Myrtle Aver				748		USA	- in the diag		
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show stry injury or other traumatic svsnt, Ira Modical Examinar toust be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3€∑Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2\(\frac{2}{2}\)\(2		was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Am Black, Whi			
5	2 hou	ted	15. Decedent's	Education	ation 16a. Decedent's Usual Occupation (Give kind of work done during most of working				6b. Kind of Business	/Industry		
7	thin 7	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	adring most of work	ing				
7	led wi	S	12		Но	memaker			In Hom	е		
2	be fill	Be	17. Father's Name (First, Middle, La.					e (First, Middle, M -	•			
Mai yiailu 21213-0030	hould d Mer marke matic	우	Oscar M. Carte		10h Mailie	an Address /Street		se Crawf	ord City or Town, State,	Zin Codo)		
2	od 2 s lith an 27 is 1 traus		Teresa Pruiett /						. Virgini			
נ	Heal Heal Heal Heal	1 8	20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City or			
2	Page: ent o nt: If ry or		1 X Kurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec		Md. Vete			)/2004 C	heltenham	, Maryland		
Dallinore,	partin Dorta	Md. Veterans Ce. 05/10/2004 Cheltenham,  21. Signature of Funeral Service Licensee  22. Name and Address George P. Kalas Funeral Hor										
Š	Depa Impo		An G. K.	also of	6	160 Oxon	Hill Road	. Kaias L Uxon hi	II. Maryl	and 20745		
	Physician		23a. P. 1. Enter the disease, or co book, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each line.	e death. Do not ent	ter the mode of dy	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a c CORONA	onsequence of): RY ARTERY D	ISFASE				Years		
	ש ב ס	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	Due to (or as a consequence of): ATRIAL_FIBRILIATION							
	be executed ician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C		UN						
		<u>a</u>		Due to (or as a c SIROKE								
DOX.	death certificate I e attending physied for use as the t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ℃ No	23c. If yes, outcome of page 1	Fetel death 3	Ectopic pregnanc Other (specify)	ÿ		23d. Date of de Month	livery Day Year		
5	at the d by the etach	Phy	9 Unknown					II as and				
, CD	The law requires that the de site has been signed by the a page 2 should be detached	by	Part II. Other significant conditions  OPD	contributing to death but r	tot resulting in the u	nderlying cause gr	ven in Part I.			o the cause of death? robably <b>火</b> 園Unknowr		
VII al necolu	a so	pie						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of		
		Completed						perform	ed?   death?	2 □ No		
2	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Magailal				n (Check only one	)			
5	S	ဥ	1 Yes 2 X No	Hospital: 1 Inpatient	2 ER/Outpatier	IL 3 DOX			ice 6 □Other (Spe	ecify)		
5	ding  After fune	ation	27. Manner of Death  XXNatural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Y	(ear) 28b. Time o	Wo	ry at ork? ]Yes 2 □No	28d. Describe hov	v injury occurred			
DIVISION	al or Atta s after de at Directo ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home, farm, sti Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,		
	To the Hospital or Attenwithin 24 hours after deatl To the Funerat Director: completely filled in by the	edical (		Physician: To the best of n aminer: On the basis of ex and manner stated	ramination and/or in							
	To the Comp	M	29b. Signature and title of pertifier	TI	se number		d. Date signed (Mon					
	j.		> Prepar Re	010	01047220	VA	05/10	0/2004				
	V	)	30. Name and address of person wh									
			Plyush R. Patel		Braddocl	k Road #	#210 Centr	eville,	Virginia	20121		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	o orginature							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 04 **Physician** JAMES E. WHITNEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS CIMI COVE SIN GER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1⊠M 2□ F 3 019-14-4975 ATTLEBURY, MASS Yrs. Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21401 USA 2305 River Crescent Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white If Yes, Give Year or Dates: ģ WWII 3X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) chemist enviromental protection 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Earl Clifford Whitney Elsie Billington 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James S. Whitney/son 401 Fairleigh Court Tracys Landing, MD 20779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee RONALO S Wall Director Baltimore, MD 21201 25a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 20 45 Examiner Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown OLIU 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 1 Yes 25 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. tnjury et Work? 27. Menner of Deeth 28d. Describe how injury occurred 5 Pending investigation 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours ethar death.

To the Funeral Director: After this certificata has bean si completely filled in by the funeral director, paga 2 should Hospital

Baltimore, Maryland 21215-0020

1 C-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5-5-104 UM Wach m 1)2476x 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Rd., ARNOLD MD 21012 211 )A13135, Wm PEN. FARM

State Registrar 31. Dete filed (Month, Day, Year)

MAY 1 2 2004

32 Registrar's Signature

To the

				for State Registrar	State of	Marylan	•	artmen rtificat				lental Hy	giene Reg. No.	004	151	85
				Decedent's Name (First, Middle	, Last)							2. Date of De Month		Year	3. Time of D	eath
		Physici /Medio		Phil:	<del>-</del>		ier					May	06	2004	11:00	рм
	7	Examir	ner	4a. Facility Name (If not institution Gilchrist				То	wson				В	unty of Death altimo	re	
		Funeral Director		5. Social Security Number 212-07-6779	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. i	ast birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da Aug.	192	9. Birth O Mar	place (State or I intry) y land	=oreign
		aryland show	_	Usual Residence of Decedent  10a. State 10b. County			, Town or Lo								10d. Inside City	
		with the Maryland e or 28a-f show	Director	Md. Balt	imore	No	tting	nam tof. Zip	Code				10a Citizen	of What Cou		M_ NO
		death with the Maryland ms 23e or 28a-f show Linust be indiffed at		7720 Bennerto	on Dr.				236				rog. Onzon		USA	
		ter death wi	Funeral	11. Marital Status	12. Was Deced Armed Ford 1 X Yes	ces?		Was Dece	dent of Hi cify Cuba	ispanic Or n, Mexica	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		Race - Amer Black, White		
W	036	ours aft	by	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da			1 🗆 Yes	2[ <b>X</b> No	Specify	:		Sp	ecity: Wh	ite	
=	15-0	n 72 h	letec	15. Decedent (Specify only highes			16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done d	durina mos	st of worki	ng	16b. Kind o	of Business/Ir	ndustry	
2	212	d withi	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		Depa		,	nief		Balti	more C	ity	
Thresday, May 6th, 2004@ 11PM	Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after and Mental Hygiene. is marked other then "neturel", or the eumatic event, It a Medical Evantari	Be	17. Father's Name (First, Middle, Philip C.	<sub>Last)</sub> Waldner							(First, Middle, appel	Maiden Sur	mame)		
٤,	aryl	should and Me s mark umatic	2	Philip C.  19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a	-		appe i I Route Numbe	er, City or To	wn, State, Zi	c Code)	
20	Z,	and 2 lealth a m 27 is		Mr. Scott Waldı	ner/ Son	20h B				ane (		Rock, F			2000	
E .	nore	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic evonce.		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)		tate	lace of Dispo emetery, crer `rison	natory or c	ther plac	,		-04		on - City or T		
Some Series	altir	permit. P Departme Importen eny injur.		21. Signature of Furieral Service	100	Gar	the same of the sa			-		the second second second		son, M	u •	
WRS	B	8988	li.	· CX	13							al Home son, Mo		<b>0</b> 4	Ai	
E				23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on ea		fatic						rrest,		Approximate Interval Betwe Onset and De	ath
		/Medical		disease or condition resulting in death)	a Due to (c	or as a consequ		20	COVI	C11	ricer				years	,
		Examiner	F.	Sequentially list conditions,	b	or as a consequ	uence of):									
		cuted nd ransit	Examiner	ri any, leading to immediate  Cause (Disease or injury that initiated events	c											
	8760,	be executed sician and burial-transit		resulting in death) Last	Due to (d	r as a consequ	uence of):									
0	9	tificate ig physi as the l	edical		d				<del></del>							
3300	Вох	eath certif attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 🗀 Fetal	death 3	Ectopic p					23d.	Date of deliv	ery Day Yea	ar
3)	0	it the dea by the a lached for	nysic	1 Yes 2 No 9 Unknown	4∐Pregna 9☐Unkno	int at time of de	eath 5	Other (sp	ecify)							
05-06-04	Division of Vital Records, P.O.	ires tha signed d be det	b	Part II. Other significant condition	ns contributing to de	ath but not rest	ulting in the u	nderlying o	ause give	n in Part	l.	23e. Did to			he cause of dea bably 4 □Uni	
8	Scor	aw requis been 2 should	Completed									24a. Was		4b. Were auto	opsy findings ava	ailable
05	II Re	The lav	Com										rmed? 2 X No	death?		\$6.01
9_	Vita	sicien: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital	patient 2	ER/Outpatier	nt 3 🗆 DO	Othe	ar-		(Check only one 5 ☐ Resid		Other (Speci	60 14.50	100
5	n of	Attending Physicien: r death. ector: After this certific: by the funeral director,	<b> -</b>	27. Manner of Death  1 Natural 5 Pendin	28a. Date o		28b. Time of Injury		28c. Injury Work			28d. Describe I			1103	
8	Sio	death. ctor: Al	icatle	2 Accident investig	not be as Blace	of Injury - At ho	me farm etr	М	1 🗆 1	Yes 2 🗆		P8f Location /	Street and N	umber or Run	al Route Numbe	ar.
NE	Di	in the	Certification:	4 Homicide determ	buildin	g, etc. (Specif)	)	oot, izotor,	, 011100			City or Tov				,
WALDNER, Phy. I.P		Hos 24 h Fur tely	Medical (		g Physician: To the Examiner: On the ba and mann	sis of examinat										
		To the within 2	Me	29b. Signature and title of certifie	1-0				. License				,	gned (Month,		
		0.4	V	I Anoth	my Mile	y un	10	Brien'	) 25	100	7.		MA	7 7,0	200%	
	1	10.1		30. Name and address of person $A$ . $R$ , $Q$	y GBM		70 1 N.	. Ch	ule	· SX	Pa	lto. n	18 2	1207	c	
		Sta Regist		31. Date filed (Month Day, Year)	2004 32. Rg	gistrar's Signa	ture	So	als							

For Stata Ragistrar

The taw requires that the death certificate be executed use as the burial-transit the attending physiclan and signed by

P.O. Box 6876

Division of Vital Records,

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker 17. Father's Name (First, Middle, Last) John J. Harvath 19a. Informant's Name/Relationship (Type, Print) Rose Suter - Daughter 2013 Smith Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 5/14/04 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 7250 Washington Blvd. Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Smolling Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death bul not resulting in the underlying cause given in Part I. þ After this certificate has been signe funeral director, page 2 should be Be Completed Cardio my o path Ischemic or Attending Physician: 25. Was case referred to medical examiner? Hospital: 2 ER/Outpatient 3 DOA Certification; To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 2 Accident Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral D

completely filled i Hospitel 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 8 1003239 MA Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Frankl rive baltimore MD 21237

8:20 P **Physician** May Bessie K. Wilkins D 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner Rosedale

If Under 1 Year | If Under 24 Hrs. tranklin wpital salt more guare 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday). 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🛛 F Hours Min. 220-30-6417 Yrs. 24. Director Maryland Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Be Completed by Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Avenue Apt. 1207 21221 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 XMarried 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) Pearl E. Rhoades 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21227 20c. Location - City or Town, State Elkridge, Maryland 22. Name and Address of Facility
Gary L. Kaufman Funeral Home At MMP., Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month 23e. Did lobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 5/10/04

Registrar DHMH 17 Rev 1/2001

State

32. Registra 's Signature

MAY 1 2 2004 >

Zane Wiatr 04-03028 RPD

4-030 PD 	)20		1 - For Unpend Item 1 - State Registrar	#25a,2	Marylan	d/Pep Ce	artment rtificate	ofsh of L	<b>93/0</b> 4 Death	and N	lental Hy	giene2 Reg. No.	004	151	87
	Physici	an	1. Decedent's Name (First, Middle, La	•		Wiatr					2. Date of De Month	Day	Year	3. Time of	
	/Medic Examin	cal	4a. Facility Name (If not institution, given 3 Parkwood Road	Zane ve street and nu		WIALI	,	Town, or	Location o	of Death	May 4	4c. Co	4c. County of Death Baltimore		
3	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bir	th			r Foreign
2	Director		213-76-0547	1 <b>X</b> M 2□F	47	Yrs.	Months	Days	Hours	Min.	Feb. 1	9,195	7 Ma	nplace (State of untry) ryland	
, ,	and wc		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside Cit	ty Limits
	Many In a	tor	Maryland Bal	Ltimore			Dunda	1k						1 🗌 Yes	2 No
	or 288	Director	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Co	untry?	
	s 23a	ral	8410 Cove Road							222			ed Sta		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, Ite Madical Examines that be notified at ance.	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	edent Ever in U. orces? 2 ☑ No ve oates:	i	Was Deced If Yes, spec 1 ☐ Yes 2				acify Yes or No Rican, etc.)		Race - Amer Black, White ecify: W		
20	72 hou		15. Decedent's E	ducation			dent's Usua kind of won			t of work	ina	16b. Kind	of Business/I	ndustry	
21	vithin 7	Completed	Elementary/Secondary (0-12)	College (		life.	DO NDT us	e retired,	l IIII	i di worki	ng .	77		J	
d 21	Hygie ther ti nt, It	Co	17. Father's Name (First, Middle, Las.	4 Year	S		Engin	eer	18. Mothe	ar's Name	e (First, Middle,		gineer	ing	
lano	id be id be ked o	To Be	Walter Wiatr	,							e Latva		mamo,		
Mary	nd 2 shou alth and M 27 is mar r traumat	-	19a. Informant's Name/Relationship Wilhelmina Watnos		Sister						al Route Number reet B				24
Baltimore, Maryland 21215-0036	Pages 1 a lent of Hes nt: If Itam ry or othe		20a. Method of Disposition  12☐ Burial 2 ☐ Cremation 3 [  4 ☐ Dopation 5 ☐ Other (Speci		State	lace of Dispo emetery, crei	natory or ot	her place			7/2004		ion - City or I		7
Balti	permit. Departm Importa any inju		21. Signature of the rai Septice Lice	Ly	W	/ 22 I	Name and	Addres	s of Facility Fune:	y ral 1	Home of	Dunda	alk, I		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that of	aused the death									Approximate Interval Betw	veen
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	Examiner			Due to	(or as a consequ	uence of):									
	uted d anslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	(or as a consequ	uenca of).									
8760,	centificate be executed inding physicien and use as the burial-transit	dical Exa	resulting in death) Last		(or as a consequ	uence of):									
9	tiffic as	Medi	IF FEMALE:										İ.		
P.O. Box	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live b	tcome of pregna birth 2 ☐ Fetal nant at time of de own	death 3	Ectopic pre Other (spe					23d	Date of delive Month	,	ear
rds, P.	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions	contributing to d	eath but not resu	ulting in the u	nderlying ca	use give	n in Part I.			obacco use		the cause of de	aath? nknown
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Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only o			21.0	
ot	Phys rthis ral dir	1: To	1X Yes 2 No 27. Manner of Death	1 🗆		ER/Outpatier 28b. Time of		c. Injury	at at		me 5 Resid			<sub>fy)</sub> At S	cene
ion	nding ith. r: Afte e fune	atlor	1 □ Natural 5 □ Pending 2 □ Accident investigation	D 3/4/(	of Injury <b>4</b> n, Day Year) <b>34</b>	28b. Time of <b>Found</b> 1:44	<b>A</b> M	Work	? es 2.[ <b>X</b> ]		Unknow	. ,			
Divis	al or Attai s after dea il Diractor od in by the	Certification:	3 Suicide 6 X Could not be determined	28e. Place buildi	of Injury - At ho ng, etc. <i>(Specify</i> n <b>d in re</b>		eet, factory,	office			28f. Location (S City or Tow Baltimo	Street and North	or Rur Parky 10	al Route Numb WOOd RO	åd
	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying P	hysician: To the miner: On the b	best of my know	wledge, death	occurred a	t the time	e, date and inion, deat	d place, a	and due to the	cause(s) and	manner as s	stated. o the cause(s)	
	To the within To the comp	M	29b. Signature and title of certifier					License . C . M					gned (Month,		
			Theoder 4. 30. Name and address of person who	mplét de us	se of death (Item	23a) (Type,			-	. Ral	Ltimore	_	, 2004 aland 2		
	CA	10	THEOLEK M. F. 31. Date filed (Month, Day, Year)	7	egistrar's Signat		T I CIL			,		,			_111101
	Sta Registr	•	WAY 1 2 2004	Sene	to the		ocks								

			For 1 State	State of Maryland / De		Health and Menta	l Hygiene	2001	15100
107	Physici	an	1. Decedent's Name (First, Middle, Last)  AND TO STATE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF T		orimoato or	2. Dat Mo		/ Year	3. Time of Death
>	/Medic		ANNE NEUMANN  4a. Facility Name (If not institution, give	WAITZ	4b. City. Town. o	or Location of Death	-	2004 County of Death	9:45 A.™
	Examin	ier		unty Hospital Center		verly		rince Geor	*op!a
	Funeral Director		5. Social Security Number 6. Sex			If Under 24 Hrs. 8 Date	e of Birth onth, Day, Year) ch 19, 1	9 Righolac	e (State or Foreign
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				. Inside City Limits
	Aaryla f sho	ō	Maryland N/A	Baltim				100.	1 XYes 2 No
	28a-	Directo	10e. Street and Number	Dartin	10f. Zip Code		10g. Citi	izen of What Country	?
	h with		329 Broxton Road			21212		U.S.A.	
21215-0036	y within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show the Medical Examiner must be natified as	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Yes, Give Year or Dates:	3. Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Specify Yelian, Mexican, Puerto Rican, e Specify:	s or No- etc.)	14. Race - American Black, White, etc Specify: White	<b>.</b>
0-10	72 ho	ted	15. Decedent's Edu (Specify only highest grade	cation 16a. De	cedent's Usual Occup	pation	16b. Ki	ind of Business/Indus	itry
21	⊆ 29	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		during most of working d)			
2			47 Fabrus Norra (First Middle 1994)	4 years	Homemak	T		Own Home	
and	ould be fit Mental H arked otl	Be	17. Father's Name (First, Middle, Last)	N		18. Mother's Name (First,			
Ž	should ind Men in marke umatic	0	Joseph  19a. Informant's Name/Relationship (Ty	Neumann	iling Address (Street	Albina and Number or Rural Route		rner	ode)
Maryland	tra					et Knolls Driv		le, Maryla	
	s 1 and f Health Item 27 other to		20a. Method of Disposition	20h. Place of Dis	position (Name of rematory or other pla	Date		cation - City or Town	
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ R  * 4 ☐ Donation 5 ☐ Other (Specify)	IGHIOVALITORI STATE	Forest Veten		04 Owir	ngs Mills,	Marvl and
alti	그 든 뿐 등		21. Signature of Funeral Service License			ess of Facility Wiedefeld Fur			rat yrana
m	Depar Impo		Level Per	Lenn	6500 York	Road Baltin	neral Ho nore, Ma	ome, inc. ervland 21	212
)	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not energy cause on each line.  Cerebrovascular		ng, such as cardiac or respir	atory arrest,	Ar In	pproximate terval Between nset and Death
	Examiner	J.	Sequentially list conditions,	Due to (or as a consequence of):  Uncontrolled Hy  Due to (or as a consequence of):	pertension	n			
3760,	ate be executed sysicien and he burial-transit	ical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Coronary Artery Due to (or as a consequence of):	Disease				
P.O. Box 68	at the death certificate by the attending phys tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	_	B Ectopic pregnance	у	2	23d. Date of delivery Month Da	ıy Year
	quires that n signed b uld be deta	by	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause gr	ven in Part I. 236		se contribute to the c	
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed					a. Was an autopsy performed?  Yes 2 No	death?	r findings available letion of cause of
Vital		0	25. Was case referred to medical			26. Place of Death (Check		163 26	3110
<b>1</b>	\$ 50	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1∭Inpatient 2□ER/Outpat	ient 3□ DOA Ott			G ☐ Other (Specify)	
ion of	ling After Fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	/ Wo		scribe how injury		
Division	tal or Attenders after death	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, larm, building, etc. (Specify)	street, factory, office	281. Loc City	ation (Street and or Town, State)	d Number or Rural Ro )	oute Number,
	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b	Medical	(Check only 2 Medical Examinate)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	investigation, in my o	opinion, death occurred at the	to the cause(s) a time, date and	and manner as state place, and due to the	d. a cause(s)
•	To t To t	Σ	29b. Signature and title of certifier	& MAD M	29c. Licens 200	060546	29d. Date	e signed (Month, Day	r, Year)
	10		30. Name an address of person who co		0		1.50	/	
-	10		Nirmala Yadla, M.		Drive Ch	everly, Maryl	and 207	85	
	Sta		31. Date filed (Month, Day, Year)	Y 1 2 2004	H L	att o			

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician McGoff May 2004 Windheim 7:00 Genevieve /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Villa Rosa Nursing Home Mitchellville Prince Georges 8. Date of Birth (Month, Day, Year)
Tune 30, 1906 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Days Hours Min 97 Yrs. 485-12-3974 Nebraska Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show traumatic avant, the Medical Exerting must be notified at MD Anne Arundel Churchton 1 Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "--- any injury or other traumati--20733 238 USA P.O. Box 214 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Law Offices 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be McGoff Unknown Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 421 Hamlin Club Dr., #205, Edgewater, MD 21037 Judith N. Beach (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Arlington Nat'l Cem. 6-1-2004 Arlington, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service (see see 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MALI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence/ f) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 4□Pregnant at time of death P.O. 1 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Sursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 TYes this 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Natural 1 🗌 Yes 2 No after death 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 🗌 Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) le of certifie 29c. License number 29b. Signature and 0 226 30. Name and address of person who o pleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 2 2004 Registrar

			riease Type of Frint in Black indenbie link. Ensure All Copies Are Legible.
			State of Maryland / Department of Health and Mental Hygiene
			1- State Reg. No. 2004 15 19
	Physic	ian	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  3. Time of Death
	/Medi	cal	Richard 1. Wallace, SR. May 11 2004 1332 PM
	Exami	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
3	- Francisco		Stella Maris Hospice AT Mercy Hospital BALTIMORE  5. Social Security Number 6. Sex. 7. Age (Ir yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (State or Foreign
11/2	Funeral Director		5. Social Security Number  6. Sex.  1 M 2 F  7. Age (If yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.    Months   Days   Hours   Min.    Month, Day, Year)   9. Birthplace (State or Foreign Country)    MARYLAND
23	70		Usual Residence of Decedent
1	rylan	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
13	e Ma	cto	MD BALTIMORE BALTIMORE 1040 20 NO
7	ith th	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
B	death with the Maryland rms 23a or 28a-f show Frivat be notified at	ra	1608 Rose wick Avr. 21237 USH
6	er de Items	une	11. Marital Status  12. Was Decedent Ever in U.S. Agmed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
1	OU36 hours after tural; or ite	by F	1 Never Married 2 Married 1 Yes 2 No Il Yes 2 No Specify:
7 9	215-0036 thin 72 hours af e. an "natural", or Medical Even	ed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
1	within 72 ene.	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)
	My with gient the er the	Completed by Funeral	O TRACTOR TRAILER DRIVER Local Union # 557.
(v)	nd 2	Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
10 -	arylan should be ind Mental s marked o umatic eve	2	Peter J. Wallace Theresa Law.
1	Maryland of 2 should be file th and Mental Hy 27 is marked oth rtraumatic event		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
\$	ore, M		Richard P. Wallace, Jr-Jan 200 Elin WAY Bel Air, MS 200. Location - City or Town, State
)	Pages hent of H		Cemetery, crematory or other place)
3			4 Donation 5 Other (Specify) Gardens of Faith 5-15-04 Rosedale MD
	Balt permit. Depart Import any inj		21. Signature of Funeral Service Licensee  22. Name and Address of Facility BALTI MORE, mD 21231.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
	Dhusisian		Immediate Cause (Final
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):
	Examiner		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.
W	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events c.
,	f60, te be exe ysician a e burial-		resulting in death) Last Due to (or as a consequence of):
í		dicai	d
	BOX 68 eath certifica attending ph for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Ċ	BB Bath c	lan	in the past 12 months?  1 Dive birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year
	hat the de od by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown
	Records, P.O. Box 68  The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
	rdS quires n sign		Yes 2 No 3 Probably 4 Unknown
	s bee	olete	24a. Was an 24b. Were autopsy findings available
ć	The if	Completed	autopsy prior to completion of cause of performed? death?  1 □ Yes 2 ₹ No 1 □ Yes 2 □ No
3	Ital	Be C	25. Was case referred to medical 26. Place of Death (Check only one)
7	OT VITA Physician: this certific ral director,	To E	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS NICC
1	Sh of aling Phys		27. Manper of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Injury
-	SIO teath. or: A	catio	2 Accident investigation M 1 Yes 2 No
	JIVISION OT VITAI HECOTAS, I or Attending Physician: The law requires it after cleath. Director: After this certificate has been signe d in by the funeral director, page 2 should be or	Certification:	Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	pitai		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only one)    Check only one   Check one   Check one   Check one   Check one   Check one   Check one
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	10		DA My 5/11/2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
			David, Riseberg 301 ST. PAUL PL Baltimore 21202
	Sta Regist		31. Date filed (North, Day Year) (S2. Registrar's Signature, Sports)

			For	1 10000	State of Ma	rylan	d / Departme			lental Hy	/giene	0001	1 = 1 0 1
			= State Registrar				Certifica	ate of De	eath	T	Reg. No.	2004	15191
at.	Physicia /Medic	an	Decedent's Name (     WILLIAM		E.		W	ELCH		2. Date of D Month	eath Day	2009	3. Time of Death  3.30 AM
1	Examin		4a. Facility Name (If n	ot institution, give s	treet and number)	//	4b. Ci	ty, Town, or Lo	cation of Death	13/	4c.	County of Deat	h
			1HE JS1.	605 /E	FK115/	18 5	last birthday) If Uni	der 1 Year If	Under 24 Hrs.	8 Date of B	irth	9 Birt	hplace (State or Foreign
b	Funeral Director		5. Social Security Nur 216-52-1	nber 6. Sex	M 2□F	iii yis. i ک	Yrs. Month		Hours Min.	8. Date of B	ay, Year)	19 19	ountry)
je.			Usual Residence of D	ecedent			0			,		1 110	7
	arylan Phow	۰	10a. State	10b. County		10c. City	y, Town or Location						10d. Inside City Limits 1
	8a-f	Director	MA					MORE Zip Code			10a Cit	izen of What Co	
	with t	급	10e. Street and Numb	weste	Day Day	- 1	)(	213	PO C			USA	-
	me 23	by Funeral	11. Marital Status		2. Was Decedent Ev	ver in U.	.S. 13. Was De		anic Origin? (Sa Mexican, Puerto	pecify Yes or N	0-	14. Race - Ame Black, Whit	
ဖွ	or ite	골	1 Never Mamiec	d 2 ☐ Married	Amned Forces? 1 All Yes 2 □ No If Yes, Give			10	Specify:	rticari, etc./		Specify:	e, etc.
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2	tied within 72 hours after death with the Maryland Hygiene. kher than "natural", or Iteme 23a or 28a-f ehow ant, the Medical Ezam nat must be motified a	Completed	(Specify	5. Decedent's Educ only highest grade	completed)		16a. Decedent's U (Give kind of life. DO NO	work done duri	ing most of won	king	100. K	ind of Business	n O
212	filed with Hygiene. other than	E O	Elementary/Second	ary (0-12)	College (1-4or 5+	·)	Adver.	tisina	a Re	ρ	Ba	Himore	2 Sun Vaper
힏	be filed htal Hyg d othe event,	BeC	17. Father's Name (F					18	Mother's Nam	e (First, Middle	e, Maiden	Sumame)	
ylaı	should be nd Mental marked c	Jo.		known	) h	1010	ch		Clai	ret	Sac		- 0 11 B 10 4 C
Maryland 21215-0036	C/ 40 72 8		19a. Informant's Nam	ne/Relationship (Ty)	oe, Print)		19b. Mailing Addr	ess (Street and	1	rai Houte Num	ber, City o	Dyn, State, 2	Zip Code) 21209
	1 and Health Iom 27 other tr		20a. Method of Dispo	sition	adicora	20b. P	Place of Disposition (	Vame of	tern	Date	20c. L	ocation - City or	7
M O	Pages nent of int: If it iry or o		1 ☐ Burial 2 🕅	Cremation 3 □R	emoval from State	FUAL	Cemetery, crematory of the Communication of the Com	IL CULAR	5-6	7-04	Fox	est L	HIL MA
Baltimore,	arta arta		21. Signature of Fund	eral Service License	90	Con					ium	mD Z	21093
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	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	mal a	1)-Huje	large		phone					14 months
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687	ys e	dical			I								
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Ö.	death	Physiclan/Medi	in the past 12 m		4☐Pregnant at t			specify)				Month	Day Year
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COL	v requii been s should	lete								24a. Wa	s an	24b. Were at	utopsy findings available
Vital Records,	9 4 9	Completed								aut per 1 Yes	opsy formed? 2 No	death?	completion of cause of
ita	ician: Th certificate ector, pag	a)	25. Was case referre	ed to medical				2	6. Place of Dea		-	12,100	
ž V		To B	examiner?	10	lospital: 1 Inpatier	t 2 🗆	ER/Outpatient 3	DOA Other:	4   Nutsing			6 ☐ Other (Spe	cify)
o u	ing P	inol	27. Manner of Death  1 Natural	5 Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Injury at Work?	t s 2⊡No	28d. Describe	e how inju	ry occurred	
Division of	Attending or death. ector: After by the fune	icat	2 Accident 3 Suicide	investigation 6 Could not be	28e. Place of Inju	rv - At h	ome, farm, street, fac		3 2 110				ural Route Number,
ρ	afor A	Certification:	4 Homicide	determined	building, etc.			,,		City or T	own, State	9)	
	To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: Atter this completely filled in by the funeral directors.	edical C				examina	owledge, death occur ation and/or investiga						
	o the	Me	29b. Signature and t	itle of certifier				29c. License n	number		29d. Da	te signed (Mont	th, Day, Year)
	->-0		> Parks	To 1/2	m.D,			RES-	-000		MAY	7,2	.004
	HYI			ss of person who co		ath (Iter	m 23a) (Type, Print)  NORTH W	OLFE S	STREET	BALTII	MORE	MARYL	4ND 21287
	St Regist	ate rar	31. Date filed (Montl		32. Registra	r's Signa	d low	Kal					AND 21287

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** 11:20AM Jillis ec 10 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner Gilchrist enter Towson

or 1 Year | If Under 24 Hrs. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1□M 2 F 213-78-1369 Yrs. Director Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? USA hestertielo 21015 1709 square 12. Was Decedent over in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other then other treumetic event, the Ma Elementary/Secondary (0-12) 12 TURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Gordon 19a Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 is
eny injury or other treu 1th mann 621 Creston rocest HILL MD 21050 Date 20b. Place of Disposition (Name of cometery crematory or other place)

EVANS FUNCTOR CHAPTEL 5-11-04 Forest HII MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility 2325 YORK Rd., Timonium MD 20093 21. Signature of Funeral Service L Unoth PEACEFUL ALTERNATIVES FUNERALA CREMATIONICITA. 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CANCER- METASTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 | No 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural Injury 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide within 24 hours a To the Funerel [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 10, 2008 25205 ins 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 balto md 2120% GAMC

DHMH 17 Rev 1/2001

State

Registrar

(24

MAY 1 2 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1_ For State		epartment of Health and	Mental Hygi	ene	
		135	Registrar  1. Decedent's Name (First, Middle, Las.		Certificate of Death		g. No. 2001	15191
	Physic		Millio M	hitaKor		2. Date of Death	Day Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	h	4c. County of Dea	ath
€ 38		8.	STAGNES H	CALTHEARE	BALTIMO	2.5	N/	A
	Funeral Director	П	5. Social Security Number 6. Se	X 2 F 7. Age (In yrs. last birth	Months Days Hours Min		9. Bir	rthplace (State or Foreign ountry)
	pug A		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town	or Location	ripiiiac	3,1136140	In Carolina
	with the Maryland a or 28a-f show	ro	11. 1. 1	4 Ral	1.			10d. Inside City Limits 1 Serves 2 □ No
	or 28a	Director	10e. Street and Number	1 Dai	10f. Zip Code	10	g. Citizen of What Co	
	death wi	ral	1814 N. Ber	italou Sti	21216		USA	
"	fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
215-0036	iges 1 and 2 should be filed within 72 hours after death with the Manylan It of Health and Mental Hygene.  If itam 27 Is marked other than "natural", or Itams 23s or 28a-f show or other traumatic event, the Wedical Exam and interpretations.	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B	lack
15-(	n 72 h n "natu edica	Completed	15. Decedent's Edu (Specify only highest grad	le completed) (0	ecedent's Usual Occupation Give kind of work done during most of wor ife. DO NOT use retired)	rking	6b. Kind of Business	/Industry
212	filed within Hygiene. other then "	Omp	Elementary/Secondary (0-12)	College (1-4or 5+)	landyman	6	rivate.	Companies
	be file ital Hy d othe evant,	Be	17. Father's Name (First, Middle, Last)	1 1/-	18. Mother's Nan	ne (First, Middle, Ma	aiden Sumame)	Companies
Maryland	hould be d Mental marked o matic eve	스	19a, Informant's Name/Relationship (7)	nitaker	Len	a St	one	
Ma	1 and 2 sho Health and Ism 27 Is mather traum		Mrs. Laura	Jackson 17	Mailing Address (Street and Number or Ru	Aug 3	24 Q LL	Zip Code) MJ コハカウ
ore,	of Head		20a. Method of Disposition  1 Burial 2 Cremation 3 F	20b. Place of D	isposition (Name of crematory or other place)	Date 20	c. Location - City or	Town, State
Baltimore	Part and		'4 Donation 5 ☐ Other (Specify)	IVIT, C	armel 15/15	12004 ]	Dunda	IK. Md.
Bal	permit. Pa Departmer Important: any injury		21. Signature of Funeral Service Ucens	L. Buss	23. Name and Address of Facility  Joseph L. Russ  2222W. North A	Funeral ve. Bar	Home to Md. s	21216
			23a. Pan't Enter the disease, or compleshock, or heart failure. List only of	ications that caused the death. Do not ne cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
層	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of)				unknown
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(jo	bed isit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				1
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89 x	ertifica ling ph	a a	IF FEMALE:					
Вох	death certific e attending p ed for use as	Physician/M	in the past 12 months?	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	ivery Day Year
P.O.		hysi	1 ☐ Yes 2 2 No 9 ☐ Unknown	9□ Unknown				
S,	The law requires that the ate has been signed by thoage 2 should be detache	by	Part II. Other significant conditions con	stributing to death but not resulting in th	e underlying cause given in Part I.		cco use contribute to	
Records,	v requi	eted				-		obably 4 Unknown
Re	The lavate has	Completed				24a. Was an autopsy performe	d? prior to c	topsy findings available completion of cause of
		Be C	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes 2 ☑ h (Check only one)	iNo 1 ☐ Yes	2 No
of V	Phys this al dir	ို	16 162 5 140	ospital: 1 Inpatient 2 ER/Outpa	itient 3 DOA Other: 4 Nursing Ho	ome 5 Residenc	e 6 Other (Spec	eify)
	ng fter inei	tion	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim- Injur	e of 28c. Injury at ry Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	or Attanding after death. Diractor: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stree	et and Number or Rui	ral Route Number,
Ö	ital or urs afte ral Dii					City or Town, S	·	
	To tha Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  Check only one)	ician: To the best of my knowledge, dener: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	With To To To To To To To To To To To To To	2	29b. Signature and title of certifier	2 MD	29c. License number  D 0 0 5 3 3 /		Date signed (Month	
•	0		30. Name and address of person who co	mpleted cause of death (Item 23a) (Typ	D005331 D0, Print) 20 catin Avenue	RII		
	2		Michelle Heng 31. Date filed (Month, Day, Year)	SUPP, MD 9	60 caren ruence	, walt	more, 1	UU
	Sta Registr		8884	32. Hegistrar's Signature				
				000	and I			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1_ For State		partment of Health and Nertificate of Death		/ 11111	15195
		Registrar  1. Decedent's Name (First, Middle, Last)		erillicate of Death	Reg. N		3. Time of Death
Phys	ician dical	BETTY YANCEY			MAY IT		1323 M
	niner	4a. Facility Name (II not institution, give street WNIVERSITY OF WARYLAND	t and number)  DWED (ALCENTER	4b. City, Town, or Location of Death	4	c. County of Death	
Funer	al	5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	ay) If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		plece (State or Foreign
Direct		2/8-22-4636 1 M	2 Yrs	.	06 09	25 Nor	th around
yland		10a. State 10b. County	10c. City Town or	Location			10d. Inside City Limits
Ba-f el	ector	Ma. NIT	Dal	10f. Zip Code	100 (	Citizen of What Cou	
death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number	Man Ave	21223	, og.	(1.5.1	4
r death	Inera	11. Marital Status 12.	Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
Vithin 72 hours after sens. Then "naturel", or Ite than "naturel", or Ite than "naturel".	J. A	1 Never Married 2 Married 3 Widowed 4 Divorced	☐ Yes 2 ☐ Mo f Yes, Give /ear or Dates:	1 ☐ Yes 2 ☐ No Specity:		Specify:	ack
2-C 72 hou nature	eted	15. Decedent's Education (Specify only highest grade con		cedent's Usual Occupation ive kind of work done during most of work	king 16b.	Kind of Business/Ir	ndustry
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	ح	IN DIC	e)
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Marylan lal Hyglene. d other than "naturel", or items 23e or 28e-1 ehow event, I'm Myddal Examine make notilled as event, I'm Myddal Examine make notilled	Be		, +	18. Mother's Nam	e (First, Middle, Mand	en Sumame)	
		Glorge Cr	Print) 1 19b. M	ailing Address (Street and Number or Ru	( Route Number Co	V or Town, State, Zij	in Code)
re, Maryiz s 1 and 2 should f Health and Mer item 27 is marks other traumatic		In Frucia Toli	verklauther	-742 (mrus)	4030 D	et Ha	1.21229
More, Peges 1 a ent of Hec nt: If item		20a. Method of Disposition	remetery (	sposition (Name of ) crematory or other diace)	Date 20c.	Location - City or T	own, State
		* 4 □Donation 5 □Other (Specify)  21. Signature of Funetal Seprice □sensee	Arva	22. Name and Address of Secility	11/07 7	rutul	1 Year
Departit. Department importa	ODC	<b>&gt;</b> // / /		Hari P. Ch	St. Ba	1 filmore	10212 aw
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cannot be a second shock of the shoc	ons that caused the death. Do not ause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Physicia /Medic		Immediate Cause (Final disease or condition resulting in death)	SEISIS  Due to (or as a consequence of):				4 DAYS
Examin		Samuelia lie lie conditions	Due to (or as a consequence or).				
pe pe	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		Ŷ.		
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d / 60, cate be executed physicien and the burial-transit	dical						
oertific certific rding p	/Me	IF FEMALE: 23c.	If yes, outcome of pregnancy			23d. Date of deliv	/ery
death cert death cert death cert death cert death cert death cert death	Physician/Me	in the past 12 months?	1□Live birth 2 □ Fetal death 4□Pregnant at time of death 9□ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
Hecords, P.O. Box 63 The law requires that the death certific ten as been signed by the attending page 2 should be detached for use as	Phy			e underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Division of Vital Records, for a standing Physician: The law requires tater death.  Director: After this certificate has been signed in by the funeral director page 2 should be a	ع ا				1 ☐ Yes	2 □No 3 □ Pro	bably 4 Unknown
ecords taw require as been sign	Completed				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
of Vital Rec hysician: The taw his certificate has to literator page 2 s					performed 1 ☐ Yes 2 🛣		2 □ No
VIII ysician s centif	To Be	examiner?	ital:   Impatient 2   ER/Outpa	Other	th (Check only one) ome 5 Residence	6 ☐Other (Speci	ify)
VISION Of VITA Attending Physician: r death. sector: After this certific			8a. Date of Injury (Month, Day Year) 28b. Tim	ry Work?	28d. Describe how in	jury occurred	
DIVISION OF OT ATTENDED PROPERTY OF ATTENDED PROPERTY OF ATTENDED IN PARTY 100	2 Accident investigation 3 Suicide 6 Could not be determined	8e. Place of Injury - At home, farm	M 1 Tes 2 No	28f. Location (Street		ral Route Number,	
Div	Cortification.	4 Homicide	building, etc. (Specify)		City or Town, St	110)	
DIVISION To the Hospitel or Attention 24 hours after deall To the Funeral Director:	adical la		an: To the best of my knowledge, d On the basis of examination and/o and manner stated.	eath occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as a and place, and due	stated. to the cause(s)
To the Within 2 To the	N N	29b. Signature and title of certifier	O mariner states.	29c. License number	29d. I	Date signed (Month,	, Day, Year)
l.	1	> DXMMINE	1).	00060997	M	ay 10, 20	04
	1	30. Name and address of person who comp		rpe. Print) STEET BALTIMOFE	E, MARYLA	ND 21201	1
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	land			
Reç	gistrai	MAY 1 2 2004	The state of the s	papares			

**Physician** /Medical Examiner

and

detached

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Completed

Be

2

Certification:

Medical

P.O.

24/0

Albert, Arnold Top: 3

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-1 shot other treumatic event, the Newtital Experiment nast to neithing at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than enty injury or other freumatic event, the Na ORGS.

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036



IL LF	MALE:
23b.	Was decedent pregnant
	in the past 12 months?
	1 ☐ Yes 2 ☐ No
	9 🗌 Unknown

			/	
at resulting in	the under	ving cause	a given in	Pa

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?				
1 🗆 Yes	2 [XNo	3 Probably	4 Unknow	

25. Was case referred to medical	
examiner?	Hospital:

					perio	orme 2X
			2	6. Place of Death (C	heck only	one)
Inpatient	2 ☐ ER/Outpatient	3□ DOA	Other:	4 ☐ Nursing Home	5√□ Res	idend

1 🗀 183	2 (2)140	0 1 10000,	
24a. Was an autopsy	24b.	Were autopsy fi	ndings available on of cause of

6 ☐Other (Specify)

examiner?	ed to medical
1 ☐ Yes 2√☐ I	No
27. Manner of Death	1
1√∑ Natural	5 Pending

ospital: 1 🔲 Inpatient	2 ER/Outpatient	3□ :
28a. Date of tnjury (Month, Day Ye		

4 Nursing	Home	5∏ Res	idence
at	28d.	Describe	how in

2X No

death?	2 □ No	

1 Natural	5 Pending
2 Accident	investigation
3 Suicide	6 ☐ Could not b
4 Homicide	determined

'ear)	28b.	Time Intur

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

28c.	Injury at Work?	
	1 🗌 Yes	2 □ No

jury	occurred				

29a.	Certifier
	(Check only
	onel

🎇 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and City or Town, State)	Number or Rural Route Number,

	one)	_	0
29b.	Signature	and	title

Volle

2[	Medical Examiner		stigation, in my opinion, death occurred a	t the time, date and place, and due to the cause(s)
1		and manner stated.	1	
titl	e of certifier		29c. License number	29d. Date signed (Month, Day, Year)
	DAMARA	Mittenestrat	10200	APRIL 25, 2004

MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 IRVING STREET, NW, WASHINGTON, D.C. DENNIS A. PRIEBAT,

State Registrar 31. Date filed (Month, Day, Year)
APR 27

32. Registrar's Signature

Hospitel or Attending 14 hours after death. Director

To the Hospitel within 24 hours a To the Funeral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Dav Year **Physician** Nock Andrews **April** 2004 11:45 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Rockville, MD Casey House Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🖵 F Yrs. Director 272-42-4981 July 11, 1946 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam not must be notified at another. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Funeral Director MD Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7701 Zulima Court 20817 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sylvester Nock Harriet Kaliszewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7701 Zulima Court Bethesda, MD 20817 Paul Andrews, Jr. husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 29, t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Comfort 4 ☐ Donation 5 ☐ Other (Specify) 2004 Alexandria, VA 21. Signature of Fineral Service Licens 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a, Part1 Immediate Cause (Final disease or condition resulting in death) Physician Colon Cancer years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760 attending physician Physician/Medical as the Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🙀 No P.O. ф detached 9 Unknown 9 Unknown ۾ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 🔀 No 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 2 this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director; 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number certifier 29b. Signature and D35635 April 27, 2004

Registrar

State

Rockville, MD 20855

Dacks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Begistrar's Signature

Joseph Kaplan 6001 Muncaster Mill

APR 28 2004

31. Date filed (Month, Day, Year)

				partment of Health and Mental H	ygiene Reg. No. 2004	15198
	Dhuaiai		1. Decedent's Name (First, Middle, Last)	2. Date of D	eath	3. Time of Death
	Physici /Medio		KATMOND EGGENE BA	RRETT April	24 2004	520 PM
	Examir	ier		4b. City, Town, or Location of Death	4c. County of Death	
	Funeval		WASHINGTON COUNTY HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   Under 24 Hrs.   8 Date of B	Washir	gton
	Funeral Director		220-52-7357 1x M 2 F 44 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of B (Month, Days Hours Min. 2 / 4 / 4	9. Birthpt Day, Year) Count	ate (State or Foreign ry) SYLVANIA
	p ,		Usual Residence of Decedent		1900 FEMIN	SILVANIA
	faryla shov	ō	10a. State 10b. County 10c. City, Town or MD. WASHINGTON HAGERS		10	od. Inside City Limits
	28a-f	Director	MD. WASHINGTON HAGERS	10f. Zip Code	40.00	tX Yes 2 No
	3a or		36 E. WASHINGTON ST.#6	21740	10g. Citizen of What Count USA	ry?
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	B. Was Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.)		ın Indian,
36	or Ite	by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:		
21215-0036	within 72 hours after death with the Maryland ene. than "neturet", or Items 23a or 28a-f show ite Modical Examilier insette modified at				Specify: WHI!	
7.	n "ne	Completed	15. Decedent's Education 16a. Dec (Give (Specify only highest grade completed) (If (If if it))	edent's Usual Occupation re kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Indi	ustry
212	d with giene	Com	Elementary/Secondary (0-12) College (1-4or 5+) WAS	TE MANAGEMENT	SHOPPING CH	ENTER
	be filed tal Hygid d other event, t	Be	ן 17. Father's Name (First, Middle, Last)  ס און אין אין אין אין אין אין אין אין אין אי	18. Mother's Name (First, Middle	·	
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N N	d 2 sh th and th and t7 is m traum		7.222	iling Address (Street and Number or Rural Route Numb		
ē,	s 1 and I Health item 27 other to		20a. Method of Disposition   20b. Place of Disp	BOX 442 WESTMINSTER	R. MD. 21158 20c. Location - City or Tow	
altimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	ematory or other place) NTY CREMATION 4/28/04		
a	permit. Pages 1 a Deportment of Hea Importent: If item any njury or othe			22. Name and Address of FacilityFLETCHER		•
m —	89 = 8		They fight 2	254 E. MAIN ST., WESTM	INSTER, MD.	
			23a. Part1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory a		Approximate nterval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	In sufficioney		Onset and Death
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	neumonia	1	V-1-3
	nd nd transit	Examiner	Cause Disease or injury that initiated events			WRE 1 5
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287	the the	dlcal	d. HIV Infe	chon		Jeans .
ROX	death certifica e attending pl nd for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	
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J Ö	at the de I by the a stached	hys	9 ☐ Unknown 9 ☐ Unknown			
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_	Physicien: this certific ral director,	To B	examiner?	26. Place of Death (Check only of other: 4 Nursing Home 5 Residue)		
n or	ng Phys fter this neral di				how injury occurred	
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UNISION	or At after of Direct in by	Certification:	4 Homicide  4 Homicide  4 Studies	treet, factory, office 28f. Location (City or Tou	Street and Number or Rural F vn, State)	Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurred at the time,	date and place, and due to th	e cause(s)
	To t Com	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Молth, Da	y, Year)
1	)5		Mi	) 18127	4/25-1	0 V
16	9		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	hed si-	7/10
	Stat	e	31. Date filed (Month, Day, Year).  APR 2 7 2004  Start Signature	11 St. Haperstown 1	ua 21/	40
H,	Registra	ar	31. Date filed (Month, Day, Year) 7 2004 32. Registrar's Signature	goods !		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No. 2 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:45 рм Catherine R. Burkart 28 2004 4c. County of Death April /Medical 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Carroll Westminster
If Under 1 Year If Under 24 Hrs. Carroll Lutheran Village Healthcare Birthptece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours Min 1 M 25 F 93 213-10-3943 Maryland Director June 22, 1910 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County items 23a or 28a-f show Exaction must be notified at 1X Yes 2 □ No Maryland Westminster Director Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21158 USA 200 St. Mark Way Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No tf Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify ð 3 N Widowed 4 □ Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Goodyear Tire & Rubber Book Keeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is 1 and 2 should be fit.
Health and Mental H
tem 27 is marked ot Grace L. Feeney 2 Charles H. Rutledge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 Is. any injury or other treu. 12891 Mt Olivet Rd., Felton, PA 17322 Yvonne L. Brown/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Louden Park cemetery 05/03/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Prives of the fall Mome & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) the attending physician Physician/Medical for use as the *tF FEMALE* 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2 100 3 Probably 4 Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No certificate 1 Yes 1 Yes 2 No Attending Physician: the funeral director, 25. Was case referred to medicat 26. Place of Death (Check only one) examiner Other: Hospitat: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To ihis 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

30. Name and address of person who comp

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Division of Vital Records, P.O. Box 68760.

with the Maryland

29c. License number

37949

Mestmenser, Due Westminwer,

29d. Date signed (Month, Dey, Year)

			1 - State Registrar	State of Maryland / er fH/Dvr, 6331,5/1				Mental Hygie	_	15201
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Ser. Del	Physicia /Medic	al	Charles Blac  4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		Day Year 2004	17:10 M
	Examin	er			- 1				•	
	Funeral		5. Social Security Number 6. Sec	yland Hospita 7. Age (In yrs. last		Clint If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	P.G.	hplace (State or Foreign
	Director			<sup>3M 2□ F</sup> 61	Yrs.	Months Days	Hours Min.	(Month, Day, 1) 8/8/194		h.D.C.
	ow •		10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits
	Mary Fr sh	ţō	MD P.G.	Dist	tric	t Heigh	ts			1 Yes 2 □ No
	r 28s	Director	10e. Street and Number		-	10f. Zip Code		100	g. Citizen of What Co	untry?
	h wit	aiD	2203 Marbury	Dr.		207	47		U.S.A.	
	deal	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Si	pecify Yes or No-	14. Race - Ame Black, White	
980	hours after death with the Maryland turel', or Items 23e or 28a-f show at Examiner must be notified at	Ď	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			Specify:	,	Specific	lack
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<u>a</u> n	d b antico	To B	Richard Blac	kwe11			Mildre	d Tilgh	man	
ary	d 2 should be the and Mental   17 is marked o treumatic eve	-	19a. Informant's Name/Relationship (Ty	rpe, Print) 1	9b. Mailin	g Address (Street a	and Number or Ru	ral Route Number, (	City or Town, State, 2	(ip Code)
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Baltimore,	permit. Pages 1 ar Department of Hes Important: If item any injury or othe	3	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F	Removal from State	itery, crem	sition (Name of satory or other place	1		c. Location - City or	
ij	iit. P.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>			Mem . P		Control of the latest and the latest	andover,	Ma.
Ba	permi Depa Impo any ir	1	Anuel 911	mards)		Name and Address And E			Yaryuland 20	77/6
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P.O. Box	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
	res that the de igned by the be detached		Part II. Other significant conditions con			derlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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Ä	The la	E O						performe	d? death?	22No
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0 0	ding Phy I, After thi funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year) 28t	b. Time of Injury	28c. Injury Work	at c?	28d. Describe how		
sio	tendi leath, tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No	706 Leasting (Ctro	-4 d November 100	and Courts Marshar
Division	lor At after o Direct	Certification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, rarm, stre	eet, factory, office	1	City or Town,	et and Number or Ru State)	rai Houle Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. License	number	290	I. Date signed (Monti	n, Day, Year)
	L > L 0		> Rointan Far	ahitu M.D.		D	43446		5/4/04	
	4		30. Name and address of person who co	ompleted cause of death (Item 23	a) (Type, I	Print)		CI	100 40	24952
			ROINTAN FARAH	JEAR . HD 90	801 G	eorgia Al	resuit 3-	41 J. Iva	spring 120	Color
В	Sta Regista	ate rar	30. Name and address of person who con ROINTAN FAILAH.  31. Date filed (Month, Day, Year)  MAY 1 2 2004	Benevas &	1	loake				

ORIGINAL

05-03-04 @ 17:10pm

BlackWEll, Charles

			1 - State Registrar	State of M	arylan		artment o				giene ,	200	15	202
	Physici		Decedent's Name (First, Middle, Last)     PHILIP I. BROWN							2. Date of De Month APRIL	ath Day	Year	3. Time of 7:07	Death A M
	/Medio Examin	40	4a. Facility Name (If not institution, give s SUBURBAN HOSPITAL	street and number)			4b. City, To		ation of Death	AIRIL	4c. C	ounty of Dea	th	_A
	Funeral Director		149-05-7882	7. Ag		last birthday) 82 Yrs.	If Under 1 \ Months D		nder 24 Hrs. ours Min.	8. Date of Bir (Month, Da MAY 14	v. Year)	C	nthplace (State of ountry) NSYLVAN	
	the Maryland 28a-f show notified at	ctor	Usual Residence of Decedent           10a. State         10b. County           MARYLAND         MONTGOMER	Y		y, Town or Lo	cation						10d. Inside Cit	•
	or 28	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citize	n of What C	ountry?	
	ath w 23e	ra	5450 WHITLEY PARK					2081	<u> </u>		U.S.A			
36	ours after death with the Maryla al, or Itams 23a or 28a-1 sho Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 ☐ If Yes, Give Year or Dates:	No		Vas Deceden f Yes, specify □ Yes 2X		ic Origin? (Spe exican, Puerto i ecity:	cify Yes or No Rican, etc.)		l. Race - Am Black, Whi pecify:	erican Indian, te, etc. WHITE	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Marical Extrainer in that be notified anone.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or !	5+)	(Give	OO NOT use r	lone during etired)	most of worki	ng		of Business	·	
12	iled w tygier ther th		17. Father's Name (First, Middle, Last)	4		STATI	STITIA		Asthoria Nama	(Eine Middle		ULTING	3	
ryland	should be filled and Mental Hygi merked other umatic event, I	To Be	JOSEPH	BR(	OWN	10h Mailia	- 14 (0	SE	Mother's Name			HYMA		
e, Mai	1 and 2 sh Health and Im 27 is n		19a. Informant's Name/Relationship (Ty, LILIANA BROWN/WIFE 20a. Method of Disposition	•	20h P		WHITLE	Y PAR	K TERRA		T. 41		Zip Code)208 CHESDA,	
timor	rtment of trans. If its		1 ☑Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		0	emetery, cren G DAVII	natory or othe DMEM.	GDNS	. 04/22	/2004	FALLS	CHURC	H, VIRG	INIA
Ba	permit. Departr Importa any inj		21. Signature of Funeral Service License	Ludeu	vg	/ 10	91 ROC	KVILL		ROCKV	ILLE,	INC. MARYI	AND 208	
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each li	osi s	3	er the mode o	raying, suc	en as cardiac o	r respiratory ai	rrest,		Approximate Interval Betwoonset and D	Neen
Am	be executed iteian and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
- 707	ate hys	dical		Due to (or as	a consequ	uence or).								
10 4 AT	that the death certific ed by the attending pl detached for use as t	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	I death 3 🗌	Ectopic pregr Other (speci				230	d. Date of de Month		'ear
4 2  rds, P	ed ed		Part II. Other significant conditions con	-				e given in F	Part I.		obacco use ∕es 2⊡i		o the cause of de	eath? Inknown
PTH 14	elaw hasb je2st	Completed		. , coagu						24a. Was autop perfo 1 ☐ Yes		prior to death?	utopsy findings a completion of ca	ivailable iuse of
HILIP DEATIF	yeician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	osnital:	-				Place of Death	(Check only o	ne)			
工厂节	ing (fte	lon; To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	rv T	ER/Outpatient 28b. Time of Injury	28c.	Injury at Work?	1	ne 5 🗆 Resid 8d. Describe h			cify)	
SKO WN F FTE FIME O Division	or Attenditer deatl	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	ome, farm, stre	M eet, factory, of	1  Yes		8f. Location (S City or Tox	Street and f m, State)	Vum <i>ber or R</i> i	ıral Route Numb	) <del>0</del> 1,
DATE	To the Hospital within 24 hours a To the Funeral i completely filled	Medical C	29a. Certifier 1  Certifying Phys (Check only one) 2  Medical Examir	sician: To the best ter: On the basis of and manner sta	f examina	wledge, death tion and/or inv	occurred at the estigation, in	ne time, dai my opinion,	te and place, a , death occurre	nd due to the d	cause(s) and pl	id manner as ace, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7			29c. Li	cense num	ber				h, Day, Year)	
Z Z	10		30. Name and address of person who co	M.D mpleted cause of d	•	1 23a) (Tvoe I		5643				21/20		
	Sta	10		ban 9°					nie, R	ockuille	ma	2085	0	
	Registr		APR 2 7 200	4 1275	مهميرين	13	Span	Kal						

			1 - For State Registrar	tate of Maryland / D	Department of Ho Certificate of E			ene 2004	15203
	Physici	an	Decedent's Name (First, Middle, Last)	DUDCED			2. Date of Death Month	Day Year	3. Time of Death
e de la composition della comp	/Medic	cal	RAYMOND C. E	BURGER	4b. City, Town, or	Location of Death	APRIL	22 2004 4c. County of Deat	22:00 M
	Examili	lei	MONTGOMERY GENERAL		OLNEY			MONTGOM	
	Funeral Director		5. Social Security Number 6. Sex 183 M	7. Age (In yrs. last birt	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Sept. 2	9. Birt 7,1929	hplace (State or Foreign untry) 0 h i o
	aryland show	<u>.</u>	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town					10d. Inside City Limits
	the Ma	ecto	Md. Montgom	ery 0	l ney		10		1 Tyes 2 StNo
	h with	ai DI	3420 North High St	reet		832	· ·	Jnited Sta	•
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.  Depertment: If term 27 is marked other than "natural", or Items 23e or 28e-f show fimportant: If term 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic svent, I'm Medical Evantinar must be notified at once.	y Funerai Director	1 ☐ Never Married 2 ☑ Married	Was Decedent Ever in U.S. Armed Forces? I⊠Yes 2 □ No IYes, Give Korean	13. Was Decedent of His tf Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
Ś	2 hours	ed by	15. Decedent's Education	on 16a.	Decedent's Usual Occupa	tion	16	Sb. Kind of Business/	
21213	d within 72 piene. r than "na	Completed	(Specify only highest grade con	mpleted) College (1-4or 5+)	(Give kind of work done di life. DO NOT use retired) Dentist	uring most of worki	ng	Dentist	
ישוום י	uld be filed Aental Hyg rked othe tic svant,	To Be C	17. Father's Name (First, Middle, Last) Al bert Burger			18. Mother's Name Clara	(First, Middle, Ma	aiden Sumame)	
ō	and 2 should ealth and Men π 27 Is marke isr traumatic		19a. Informant's Name/Relationship (Type, I Ann W. Burger / Wi		Mailing Address (Street at 420 North Hi				tip Code) 20832
ນ	Pages 1 a nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State cemeter	Disposition (Name of y, crematory or other place politan Crem	)		oc. Location - City or	
	permit. Depertm Importa sny Inju		21. Signature of Funeral Service Licensee  Marriel H. B.	orher	22. Name and Address Muriel H	of Facility Barber	Funeral		20882
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one call immediate Cause (Final	ons that caused the death. Do nause on each line.					Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due 10 (or as a consequence of	Volue lu	3			5 days
	ned insit	Examiner	Sequentially list conditions, if any, reading to in mediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence of	ж <b>)</b> .				
,0070	cate be executed physicien and the burial-transit	al Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of	of):				
00	tificate ng phys as the	Aedical	0					=1=3	
O. DOX	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	f yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli Month	very Day Year
us, r	juires that n signed by ild be deta	by	Part II. Other significant conditions contributed to the contribute of the contributed to	uting to death but not resulting in	the underlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ecords,	law rec as bee	Completed	Periferal Va	sulve dise	ase		24a. Was an autopsy	prior to c	topsy findings available completion of cause of
		e Con	Cerebral Va 25. Was case referred to medical	scular dis	ease	26. Place of Death	performe		2 No
5	Physician: this certificinal director,	To B	examiner? 1 Yes 2 No Hosp	ital: Inpatient 2 ER/Out	tpatient 3 DOA Other			ce 6 ☐Other (Spec	eify)
NISIOII O	ath. rr: After the funera		1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury 28b. T (Month, Day Year) Ir	njury Work'	at ? es 2 □ No	28d. Describe how	injury occurred	
200	tal or Atters after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	3	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Phwithing 4 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination and and manner stated.	, death occurred at the time d/or investigation, in my opi	e, date and place, a inion, death occurre	and due to the cau ad at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	111	29c. License			I. Date signed (Month	
•	211		30. Name and address of person who complete	eted cause of death (Item 23a) (	Type. Print)		17	or 11 x 3	100/
			ARTHUR Woodeness	3416 Oken	durand C	7 Ola	vey to	Tanyland	1 20832
	Sta Registr		APR 2.6 2004	Denerous /	1 sporker		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2004 April 23, 6:50P Ethel Hall Bere 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Dec. 5, 19 5. Social Security Number 6 SAY 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1□M 2\ F 93 Yrs. 260-40-5617 1910 North Carolinia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10413 Gary Road 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James M. Hall Ethel Sebrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10413 Gary Road, Potomac, Maryland James M.H. Gregg/Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20a. Method of Disposition 20c. Location - City or Town, State April 26. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 14 ☐ Qonation 5 ☐ Other (Specify) 2004 Bethesda, Maryland Crematorium, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 Years Chronic Lymphocytic Leukemia disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Directo

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Completed

Be

**Funeral** 

Director

r than "natural", or items 23a or 28a-1 show the Medical Examinant must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heath and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23s amy pirupy or gather traumatic event. It a Medical Expansion final once.

Baltimore, Maryland 21215-0036

with the Maryland

attending physician and for use as the burial-trans signed by the a peen page 2 certificate this s after death. filled in by the funeral

The law requires that the death certificate be executed

Attending Physician:

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To the Hospital within 24 hours a To the Funeral C the Hospital

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Senile Dementia of Alzheimer's Type 24a. Was an performed? Yes 24 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 은 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 💢 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 2 8 2004

Aruna S. Nathan, M.D. 32. Registrar's Signature Bylonon

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11125 Rockville Pike, #208, Rockville, Maryland Darkas

29c. License number

D0053615

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

April 26, 2004

		•	For State Registrar	State of M	aryland	-	artment <i>tificate</i>			ind M	ental Hy	/giene Reg. No.	2004	15205
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     Teresa L. Bowen     4a. Facility Name (If not institution, give				4b. City, To	own, or l	Location o	f Death	2. Date of D Month April	25, 2	Year 2004 County of Deatl	3. Time of Death 3:15 P M
	Funeral Director		Washington Advent 5. Social Security Number 6. Sec 218-66-4081			as <i>t birthday)</i> Yrs.	Tako: If Under 1 Months		Park If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, D July 9	irth	ntgomer 9. Bird Wash	nplace (State or Foreign unity)
	ט	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome  10e. Street and Number  11404 Channing Dri	<u>,                                      </u>		r, Town or Lo						10g. Citi:	zen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No untry?
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23s or 28e-f show tha Medical Examinar must be routified at	þ	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	)	16a. Dece	Was Decede f Yes, specif 1 Yes 2	nt of His y Cuban No	Specify:		ocify Yes or N Rican, etc.)	0-	4. Race - Amer Black, White Specify: Whi	ncan Indian, a, etc. te
and 21215	d be filed within 7 sntal Hygiene. ced other than "n c avant, the wed	be Completed	(Specify only highest grad  Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)  Edward R. Bowen	College (1-4or	5+)		kind of work DO NOT use Spersol	1	18. Mothe	r's Name	(First, Middle .dwe11	e, Maiden	Retai Sumame)	1
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ta marked other than "natural", or Itema 23a or 28e-f show any injury or other traumatic avant, the Medical Exarcated must be rediffed at once.	To	19a. Informant's Name/Relationship (Ty Edward R. Bowen/Fa  20a. Method of Disposition 1  Burial 2  Cremation 3  F  4  Donation 5  Other (Specify)	ther	20b. Pl	14A I	Parkwa Parkwa Patory or oth Prium,	y Rd of er place Inc	nd Numbe	rorRura reen prif 200	belt, bata 30,	Maryl 20c.Lo Beth		70 Town, State Iaryland
Balti	permit. Departm importa any inju		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complete	N	101353	B RO	Name and ockvil ockvil	Address le, le,	Inc. Mary	land	20850	)	rey Fu gomery A	neral Home/ Avenue
8760,	death certificate be executed  Wedical  a attending physician and of or use as the burial-transit	icai Examiner	shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Pneumo Due to (or as Pneumo Due to (or as Due to (or as Due to (or as	nia nia a consequ thora a consequ	uence of):  X uence of):								Interval Between Onset and Death
O. Box 6	death certific a attending p of for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🏋 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Fetal	death 3	Ectopic prec Other (spec					2	3d. Date of deli Month	very Day Year
Vital Records, P.	The law requires ate has been sign page 2 should be	Completed by Ph	Part II. Other significant conditions co Drug Abuse	ntributing to death t	out not resu	ulting in the u	nderlying cau	ise give	n in Part I.	_	1	Yes 2 [ s an opsy formed?	24b. Were au prior to death?	the cause of death?  bably 4 \( \) Unknown  topsy findings available completion of cause of  2 \( \) No
Division of Vita	To the Hospital or Attending Physicien: Th within 24 hours after death.  To the Funaral Director: After this certificate completely filled in by the funeral director, pag	ertification; To Be	25. Was case referred to medicat examiner?  1 X Yes 2 No  27. Manner of Death  1 X Natural 5 Pending investigation  3 Suicide 6 Could not be determined	Hospital: 1 X Inpati 28a. Date of Inju (Month, Date of Injuicition of Injuicition of Injuicition of Injuicition of Injuicition of Injuicition of Injuicition of Injuicition of Injuicition of Injuicition of Injuicition of Injuicition of Injuicity of Inju	ury ay Yeer)		M 28	injury Work 1   Y	r: 4 □ Nui at	rsing Hor	28d. Describe	sidence 6 how injury	d Number or Ru	ral Route Number,
۵	• Hospital or A 24 hours after • Funaral Dire letely filled in by	edicai Cert	29a. Certifier (Check compone)  1 Certifying Phy 2 Medical Exami	sician: To the best	of my know	wledge, deat					and due to the	a cause(s)	and manner as	
<b>;</b>	To the To the complet	Med	29b. Signature and title of certifier  30. Name and address of person who co	(	Ont.		D	License	number	1.5			1 29, 2	
	Sta Registi		Carl I. Margolis,  31. Date filed (Month, Day, Year)  APR 3 0 200	32. Regist	25 Ro rar's Signa		e Pike			Roc	kville	, Mar	yland 2	0852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1,29C, 30 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Cecil Co. KP 4/28/04 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Campbell 5 2 2 **Physician** APRIL 16:27 PM ALPHONSO CATABELL WILLIAM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea May 30, 1 **Funeral**  Birthplace (State or Foreign Country) Days Hours 1**∑**M 2□F 243-74-5932 Yrs Director 56 1947 North Carolina Usuel Residence of Decedent filed within 72 hours after death with the Maryland Hygiane. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or items 23a or 28a-f sho Directo 1 Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 53 E. Bel Air Avenue 21001 **USA** Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. t ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver Cab Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked oth any lighty or other traumatic even 9DR. Milton Campbell Willie Mae Leazer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Campbell / brother 124 E. Mill Ave., Capital Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Oakwood Cemetery 5/3/04 Salisbury, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTI SYSTEM ORGAN FAILURE /Medical Due to (or as e consequence of) **Examiner** CRYPTECOCCAL MENINGITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires thet the death certificate be executed CHRONIC IMMUNDSUPPRESSION physician ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cal Physician/Med! attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? Yes 20 No page After this certificate 1 ☐ Yes 2 ☐ No 1 Yes the Hospitei or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) I in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D time certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) P16635 ARIL 25,2004 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia L. Pena, MD 22 S. Greene Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra Carle APR 2 8 2004

			For State Registrar	State of	Marylar		artment of H		l Mental Hyg	iene eg. No. 200	4 15207
			Decedent's Name (First, Middle, L.	ast)					2. Date of Dear	th	3. Time of Death
	Physicia /Medic		Helen	Mari	e	Ca1m			April	28, 2004	1:30 a M
	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or		ath	4c. County of De	eath
			Residence 1300 A				-	ewood	50 10 5		arford
	Funeral			Sex 1□M 2⊋F	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi	n. (Month, Day,	Year) 9. 8	Birthplace (State or Foreign Country) ennsylvania
	Director		Usual Residence of Decedent	A	00				May 15,	1915   P	ennsylvania
	yland now		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Mar Mar	jo	Maryland Harf	ord			Edg	ewood			1 ☐ Yes 2 ☑ No
	or 28	Directo	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What	Country?
	ath w 23a	ra	1300 Apple Ridge					1040		U.S	
	er de	Funeral	11. Marital Status	Armed For		I.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
5	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes If Yes, Giv Year or Da	≥ Mino e ates:		1 □ Yes 2 🙀 No	Specify:		Specify:	Black
200	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f show te Moulcal Exercitor most be rotified at	ted	15. Decedent's I	Education		16a. Dece	ient's Usual Occupa	ation		16b. Kind of Busine	ss/Industry
7	hin 7	ple	(Specify only highest g	rade completed) College (1	-4or 5+)	life.	kind of work done of OO NOT use retired	ouring most of w	rorking		
V	ed wil	Completed	Twelve Years				Homemake				Residence
and	be filed within 72 hours after death with the Marylan Hygiene.  do other then "naturel", or liems 23a or 28e-f show event, tre Marical Exercitor must be redified at	Be	17. Father's Name (First, Middle, Las	s S. Ste				18. Mother's N	ame (First, Middle, I		
2	12 should be fi and Mental H is marked ot reumetic ever	ဍ	19a. Informant's Name/Relationship		wart	10h Mailir	na Address (Street	and Number or	Ella Mae Rural Route Number	9	Zin Code)
M	d 2 s Ith an 27 is i		Jean Hockaday		r)				t, Edgewo		
စ်	s 1 ar f Hea item othe		20a. Method of Disposition		20b. F	the second second second	sition (Name of natory or other place	and the same of th		20c. Location - City	
аппо	Page nent o nrt: # nry or		1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		State		Cemetery		/04/04	Darlington	n, Maryland
ם ב	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic evonce.		21. Signature of Funeral Service Lice	97500 1 (1+431)	a Sc	L		terson	& Son Fun and 2190		, P.A.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that ca	aused the deat	th. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	,		(	(1)				Onset and Death
	/Medical Examiner		resulting in death)	Due to (	or as a consec	quence of):	,,,				
	CXAIIIIIEI	L	Sequentially list conditions,	b. — Due to /	or as a consec	Tuesco of					
P	led isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or may y	Due to (	or as a consec	quence or):					
1	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (	or as a consec	quence of):					
8/00,	cate be executed physician and the burial-transit	call		d			<u>.</u>				
â	tifical ng phy as th	ed	NE FEMALE						-		12 12
X Q Q	death certificate e attending phys ed for use as the	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, out 1 ☐ Live bi	come of pregnation		Ectopic pregnancy			23d. Date of o	lelivery Day Year
		Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of cown	death 5	Other (specify)			Wildita	Day Teal
Ţ.	requires that the de een signed by the a hould be detached f		Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ďs,	uires sign ld be	d by							1 □ Y€	as 2□No 3□	Probably 4 Munknown
ecord	> 20 00	Completed							24a. Wasa	n 24b. Were	autopsy findings available o completion of cause of
Υ,	The te h age	mo							- autops perform 1 ☐ Yes 2	ned?   death	o completion of cause of ? es 2 \( \sum \) No
	icien: Tector, p	Be C	25. Was case referred to medical examiner?					26. Place of D	eath (Check only on		
0 0	hysic his ce I dire	To	1 ☐ Yes 2 ☒ No		npatient 2			4 Li Nuising	Home 5⊠Reside		pecify)
Ĕ	ing P	lon;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury	Work	/at <br Yes 2 ∐ No	28d. Describe ho	w injury occurred	
DIVISION	ttend death ctor: , the f	icat	2 Accident investigate 3 Suicide 6 Could not	be 300 Place	of Injury - At h	ome farm str	eet, factory, office	165 2 100	28f. Location (St	reet and Number or	Rural Route Number,
2	el or A s after al Direct	Certification;	4 ☐ Homicide determine	buildir	ng, etc. (Speci	fy)	oog (datoly) omso		City or Town		
	To the Hospitel or Attending Physicien: within 42 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, it	edical (			isis of examina				ce, and due to the ca curred at the time, da		
	To th within To th comp	Me	29b. Signature and title of certifier	/ =/			29c. License	number	2	9d. Date signed (Mo	nth, Day, Year)
			1 6. 12	well &	MD			14280	10/	4/20	1/04
	5		30. Name and address of person who	319	S. UNI	ON AV	Print)	16	MA 21	078	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 9 2004	/32. R	egistrar's Sign	ature		/	/		

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 1, Year 2004 **Physician** 1:40 A M Lottie Calkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Nov. 13, 1918 | NewYork 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M X□ F 080-03-6413 85 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County in than "natural", or itams 23a or 28a-f ahow the Medical Examination to colling at 1 Yes 2 No Directo Waldorf Charles Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20602 317 Garner Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11 Marital Status Black White etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or flar any injury or other trainmetre. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Yes Give Specify: ģ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Millie Cornell Hamilton Vanderveer ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Garner Avenue, Waldorf, MD 20602 <u>Jean M. Silva - Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-10-04 Ambler, PA White Marsh Mem. Pk 4 ☐ Donation 5 ☐ Other (Specify) Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 21. Signature of Funeral Service Licensee M01341 ohn 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LOW CARDIAC **Physician** 001 VECKS /Medical Due to (or as a consequence of): **Examiner** DYS FUNCTION VENTRICUL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit MYOCAR SIAL and Due to (or as a consequence of): Box 68760. the attending physician YEARS Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 3 ☐ Probably 4 🗗 € nknown 1 ☐ Yes 2 ☐ No COAGULOPATHY page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No STENOSIS 24a. Was an certificate has autopsy performed 1 Yes 2 No Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending 5 Pending investigation 1 PNatural 1 ☐ Yes 2 ☐ No M death. 2 Accident hours after death uneral Diractor: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 18551 Jelle Mel MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKOMA PARK, MD. 7610 CARROLL AV. NEIMAT, NO. 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Chester Merle Cartzendafner 2004 May 1712 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5313 Taneytown Pike Carroll County Taneytown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral**  Birthplece (State or Foreign Country) 1⊠M 2□F 216-10-8222 Director 85 June 17 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits rall, or Items 23a or 28a-f shov Examiner must be notified at Maryland Carroll County Taneytown Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5313 Taneytown Pike 21787 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene.
The marked other than "natural", or flee and the traumatic event, the Medical Engine ury or other traumatic event, the Medical Engine 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d Hygiene.
A other thar
c event, I'm Elementary/Secondary (0-12) College (1-4or 5+) route salesman 12 bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesse Cartzendafner ဥ Flora Bell Angell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Champagne / daughter 32 Laurel Court Nashua, New Hampshire 03062 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. May 7, Mt. Pleasant Cemetery Taneytown, Maryland <sup>4</sup> □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** CVI vn. nutes resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (units a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physicien Physician/Medicai as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death ed by the a detached f 5 Other (specify) o 9 Unknown been signed is should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autoosy performed? certificate 1 Yes 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home SAResidence 6 Other (Specify) 2 3 DOA hours after death.

Ineral Director: After this

y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō Hospital To the Funeral 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 25 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hend erson I MO 2673 Marchester Rd Wanchester Mi) 31. Date filed (Month, Day, Year) 32. Registrar Signature State 2004 Registrar

			•	State of Maryland / Dep	eartment of Health and Nertificate of Death	∕lental Hygid	_	15210
i	Physici /Medic	cal	Decedent's Name (First, Middle, Last)     Barbara Jean Cas     As. Facility Name (If not institution, give stre	shman	4b. City, Town, or Location of Death		3 <sup>Day</sup> 2004 2004	3. Time of Death 9:55P. M
4	Examir Funeral Director	ler	Laurel Regional Hosp  5. Social Security Number 6. Sex		Laurel	8. Date of Birth (Month, Day, ) Nov. 18, 1	Prince Geo	orge's    lace (State or Foreign
		tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Geo	10c. City, Town or L		10001071		0d. Inside City Limits 1 Yes 2 No
	h with the 23a or 28a	al Direc	10e. Street and Number 4509 Yucca Street		10f. Zip Code 20705		Citizen of What Cour United Stat	-
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow emportant: If item 27 is marked other than "natural", or items 23a or 28a-f ahow emportant: If item 27 is marked other than "natural" and the multiled at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ★ No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
1215-0	within 72 ho lene. than "naturi the Macral I	Completed	15. Decedent's Educat (Specify only highest grade c	College (1-4or 5+)  (Givenilite.	edent's Usual Occupation e kind of work done during most of won DO NOT use retired) retary	king	Sb. Kind of Business/In Furniture V	
Maryland 21215-0036	ould be filed Mental Hygi arked other atic event, I	To Be C		rausburg	18. Mother's Nam Nettie I	e (First, Middle, Ma Mae Cartr	iden Sumame) idge	
, Mar	and 2 sh Balth and n 27 is m	y gi	19a. Informant's Name/Relationship (Type, Diane M. Costello-da	aughter 4509	ling Address (Street and Number or Ru.  Yucca Street Belt	sville, I	Maryland 20	705
Baltimore,	Pages 1 nent of He ant: If ite		20a. Method of Disposition  1   → Burial 2 □ Cremation 3 □ Rem  • 4 □ Donation 5 □ Other (Specify)		position (Name of paratory or other place)  pe Memorial Park 4/2		oc. Location - City or To lkridge, Ma	
Balti	permit. Departn Imports eny inju		21. Signature of Suneral Service Licensee	tanking 15	22. Name and Address of Facility Onald V. Borgwardt 1400 Powder Mill Ro	Funeral 1. Beltsv	Home, P.A.	and 20705
p	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	tions that caused the death. Do not er cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
),	Medical Examiner and Asician and Parial-transit	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Atrial Fibrillati  Due to (or as a consequence of):  Acute Diverticuli  Due to (or as a consequence of):	1200	y Disease		
68760,	ficate be physicials the bur	edicai	d	Descending ulcer				
O. Box	wrequires that the death certificate been signed by the attending phys should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
۵.	The law requires that the site has been signed by thoage 2 should be detached.	ed by Pł	Part II. Dther significant conditions contri Left lung carcinoma				cco use contribute to the	
al Reco	The farate has		Severe Osteoporosis				prior to co death? ₹ No 1 ☐ Yes	psy findings available impletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	tion: To Be	1 162 2 140	pital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Yeer) 28b. Time Injury	ent 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residen 28d. Describe how	ce 6 □Other (Specif	y)
Divisi	ital or Attenirs after deal	Certification:	2 □ Puiside 6 □ Could not be	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	the Hosp in 24 hou the Fune	Medical	(Check only 2 Medical Examine one)		ath occurred at the time, date and place investigation, in my opinion, death occu-	red at the time, dat	e and place, and due to	the cause(s)
	with	2	29b. Signature and title of certifier	- min	D013687		Dril 24, 20	
			30. Name and address of person who com Joselito Magday, M	I.D. 11701 Roby Av	enue Beltsville, M	aryland 2	0705	
ľ	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 27 200	32. Registrar's Signature	Sparks			

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>004</u> **Physician** 10:15 P M 28, APRIL COHEN SHIRLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner**  ${ t MONTGOMERY}$ ROCKVILLE HEBREW HOME OF GREATER WASHINGTON Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** POLAND 1 □ M 2 🌣 F 99 Director 060-34-4017 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f ehow of Health and Mental Hygiene. Item 27 le marked other than "natural", or Items 23a or 28a-f ehov other treumatic event, if a Medical Examiner must be notified at 1 X Yes 2 □ No Funeral Director ROCKVILLE MARYLAND MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 U.S.A. 6111 MONTROSE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Be Completed by WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT COOK 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNA TULTPAN ပ BENJAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FERN STREET, BEVERLY, MA 01915 HELENE TULLO/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permil. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State UNITED HEBREW CEMETERY 05/02/2004 STATEN ISLAND, NEW YORK \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on gady line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. nding physician use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ sign be ( 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed certificate 1 🗌 Yes a □ No To the Hospital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA į ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending s after death.

I Director; After director in by the furnishment 1 🗌 Yes 2 🗌 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 0 omoleted (Item 23a) (Type, Print and address of person 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 2004 Registrar

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			State Registrar				Ce	rtificat	e of E	Death		2. Date of De	Reg. No Z	UUL		13
П	Physici	an	1. Decedent's Name (F			T.v.						Month April 2		ης Year	3. Time o	
>	/Medic		Francis J  4a. Facility Name (If not					4b. City,	Town, or	Location of		iipi ii		ounty of De		
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	/land			b. County		10c. City	, Town or Lo	ocation							10d. Inside C	City Limits
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	or 28	Funeral Director	10e. Street and Numbe					10f. Zip					10g. Citize			
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	Item Item	une	11. Marital Status 1 X Never Married	2□ Married	12. Was Deceder Armed Force: 1 X Yes 2 [	s?	5. 13.	If Yes, spe	cify Cubar	n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	1	Black, Wh	nite, etc.	
99	72 hours after death with the Maryland natural', or Rems 23a or 28a-f ahow disal Everili actinual be notified at	by	3 ☐ Widowed 4 ☐		If Yes, Give Year or Dates		62	1 🗆 Yes	2⊠ No	Specify:			Sį	pecify: Wh	ite	
21215-0036	be filed within 72 hours after death with the Marylan ital Hyglene. id other than "natural", or flems 23a or 28a-f ahow avant, the Medical Ever ill at natal be politied at	Completed		Decedent's Edi			16a. Dece (Give	dent's Usua kind of wo DO NOT u	al Occupa rk done di	ition uring mos	t of worki	ng	16b. Kind	of Busines	s/Industry	
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an	lid be lental kad c	To B	Francis J	oseph C	ollins,	Sr.				Agn	es C	athari	ne Mur	phy		
Maryland	2 should be a sand Mental frankad ols markad o		19a. Informant's Name	/Relationship (T	ype, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	I Route Numb	er, City or T	own, State,	, Zip Code)	
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injurgue other traumatic as once.		20a. Method of Disposi 1 ⊠Burial 2 □ C	remation 3 🗆		ce	ace of Disponentery, cre Sunt O	matory or c	ther place	9)		ate 1.			or Town, State	
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Ba			) (In	he DO	Cla		F 5	ranci 00 Un	s J. ivers	Coll	ins Blvd	Funeral	l Home Silve	Inc.	ing, MD	20901
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Approximate Interval Between												te	
Į.			Immediate Cause (Final disease or condition Metastatic Prostate Cancer										Onset and 5 Yea	Death		
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Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Feat death 3 Ectopic pregnancy								230	d. Date of d Month				
o.	at the de by the a	Physiclan/M	1 □ Yes 2 □ No 9 □ Unknown	0	9☐ Unknown		Jan J		)							
σ,	es that igned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did 1	obacco use	co use contribute to the cause of death?			
ecords,	w require been sig should b											1 🗆	Yes 2█	No 3∏!	Probably 4 🗆	Unknown
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of	g Physical this		Imparient 2 Edward Terranginent September 1 Te										ience			
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	To tha Hospital or Attani within 24 hours after deatl To tha Funaral Diractor: completely filled in by the	edical	29a. Certifier   1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)   Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated.    Check only one   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.										s)			
	To tha I within 2 To tha I	Me	29b. Signature and title	e of certifies	1 11	1 1	111	29	c. License	number			29d. Date s	signed (Mo	nth, Day, Year)	
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	Dhuniai		1. Decedent's Name (First, Middle, Last)	2. Date of D Month	Day Year 3. Time of Death									
	Physicia /Medic	al	Maria A. Cortez	April	19, 2004 9:15 PM									
er.	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	,									
2.50	Funeral		13914 Bauer Court  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Rockville  If Under 1 Year If Under 24 Hrs. 8. Date of B	Montgomery  9. Birth (State or Foreign									
	Director		579-04-0603 1□M 2⊠F 85 Yrs.	Months Days Hours Min. (Month, D. Nov. 1	Country) 4, 1918 E1 Salvador									
	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits									
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Itiam 27 is marked other than "natural", or Itiams 23s. or 28s-f show itiam 27 is marked other than "natural", or Itiams 23s. or 28s-f show other traumatic event, It a Modical Exertiner matter notified at	ō			1 ☐ Yes 2 ☒ No									
	the 1	Director	Maryland Montgomery Silver  10e. Street and Number	Spring 101. Zip Code	10g. Citizen of What Country?									
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	r dea	Funeral		<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>	14. Race - American Indian, Black, White, etc.									
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1₺Yes 2□No Specify:Salvadoran	Specify: White									
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nd	be fill had oth avan	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middl	·									
Maryland	2 should be filed withir and Mental Hygiene. is markad other than aumatic avant, Ire M	10	Isabel Benitez  19a. informant's Name/Relationship (Type, Print)  19b. Mi	Martina Flor  Address (Street and Number or Rural Route Num										
S	and 2 s ealth an n 27 is i			810 Allison Street, Brent										
ē,			20a. Method of Disposition 20b. Place of Discember 20a.	sposition (Name of Date prematory or other place)	20c. Location - City or Town, State									
E	Pages nent of thant: If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Memoria	d National   April 24,	Laurel, Maryland									
Baltimore,	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service License	22. Name and Address of Facility	1 Home Inc									
ш	70 E 2 9	W 1		Francis J. Collins Funera 500 University Blvd. W.,S										
	law requires that the death certificate be executed as been signed by the attending physician and as been signed by the attending physician and as should be detached for use as the burial-transit		23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final											
			disease or condition resulting in death)  a. Due to (or as a consequence of):	Carcinoma										
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	death e atte	Physiclan/M	in the past 12 months?  4 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)	Month Day Year									
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	uires tha signed I id be det	by	Part y. Other significant conditions contributing to death but not resulting in the	_	Yes 2 No 3 Probably 4 Unknown									
orc	w requir been si should	etec	Tay ber torretor	24a. Wa										
Records,	The law ate has page 2 s	Completed		aut per	opsy prior to completion of cause of death?									
Vital	ling Physician:  After this certification of the control of the co	ø.	25. Was case referred to medical	1 ☐ Yes 26, Place of Death (Check only										
ί		To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpa	tient 3 DOA Other: 4 Nursing Home 5 Re	sidence 6 Sother (Specify) S residence									
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Division	after of Dirac	ertif	4 Homicide determined building, etc. (Specify)	City or T	City or Town, State)									
	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	edical Certification:	29a. Certifier 12 Certifying Physicien: To the best of my knowledge, d	eath occurred at the time, date and place, and due to the	e cause(s) and manner as stated.									
	tha Ho hin 24 t tha Fu npletel	edic	(Check only one) Medicel Exeminer: On the basis of examination and/o and manner stated.											
	To t To t	Σ	29b. Signature and with of certifier	29c. License number	29d. Date signed (Month, Day, Year)									
	4		OM WHILL	1748 gr	1811									
			30. Name and address of person who completed cause of death (Item 23a) (Ty Shelly Williams M.D. 1109 Spring	pe.Print) g Street, #201, Silver Sp:	ring, MD 20910									
	St	ate ,	31. Date filed (Month, Day, Year) 32. Registrar's Signature											
	Regist	rar	APR 27 2004 Jenewa &	Sporks										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#4 coerMD5/3/04, PMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** George 1:35 AM DY 2004 26 /Medical 4c. County of Death Prince Georges 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rennaisance Garden at Riderwood Village Silver Spring If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1⊠M 2□F Director 85 579-18**-**9268 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f si other traumatic evant, It is Madical Examinar mat be multified 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3124 Gracefield Road, #119 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify þ If Yes, Give Year or Dates: WWII 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 'anay injury or other traumatic evant, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber/ Welder Department of the Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ George Simon Craver Nellie Dailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hope W. Craver/ Wife 3124 Gracefield Road, #119, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State April 28, ¹ 4 □ Donation 5 □ Other (Specify) Mt. Carmel Cemetery Sunshine, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rneumoma disease or condition 3 days resulting in death /Medical Due to (or as a consequence of) zaminer avanced years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To tha Hospital or Attanding Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pertension 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 No 24a. Was an page 2 s 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 Mo 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor; the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 Homicide .⊆ within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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Loveen

31. Date filed (Month, Day, Year)

LOVEEN PUTHUMANA

3110 GRACEFIELD

32. Registrar's Signature

ruthumana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sparks

D59524

26,2004

		For State Registrar		State of	Marylan		irtment of H		d Mental H	giene Reg. No.	2004	1521
Physici	an	Decedent's Nam		•					2. Date of D Month	Day	Year	3. Time of Death
/Medic Examin		4a. Fecility Name ( Men  5. Social Security N	Number 6.	tesp.	7. Age (In yrs.	last birthday) Yrs.	4b. City, Town, or Fast If Under 1 Year Months Days	for If Under 24	Death Hrs.   8, Date of B	4c. Cou	unty of Death	place (State or Foreign
Director		213-42-0 Usual Residence of	228 of Decedent	- 4					JUNE 2	23, 194		
the Marylar 28a-f show	ō	MD MD	10b. County	BOT		y, Town or Lo <b>T. MIC</b>					1	0d. Inside City Limits 1 ☐ Yes 2 No
ith the P or 28a-	Director	10e. Street and Nu		1001	, ,	T. LITE	10f. Zip Code			10g. Citizen	of What Cour	ntry?
ath wit		7308 D	RUM POIN					21663			USA	
ified within 72 hours after death with the Maryland Hygiene. Hygiene Then "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funerai	<ul><li>11. Marital Status</li><li>1 ☐ Never Marital</li><li>3 ☐ Widowed</li></ul>	ried 2 Married 4 Oivorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 <b>X</b> ) No 9	1	Vas Decedent of H Yes, specify Cuba	ispanic Origin an, Mexican, P Specify:	? (Specify Yes or N Puerto Rican, etc.)		Race - Americ Black, White, ecity: WH	
72 hours "natural",	ieted	(Spe	15. Decedent's E cify only highest g			(Give	ent's Usual Occupa kind of work done of OO NOT use retired	during most of	working	16b. Kind o	of Business/In	dustry
be filed within 72 ho tral Hygiene. Ind other then "natu	Completed	Elementary/Second 12	ondary (0-12)	College (1-	-4or 5+)		OMEMAKER	1)		OWN	HOME	
	Вес	17. Father's Name	(First, Middle, Las	t)				18. Mother's	Name (First, Middle			
should be ind Mental in marked o	유		D M. LEW			40h M-85	- Add (C44		XUAV		. 0	
2 2 2 2 C		19a. Informant's N	ame/Helationship		KR.				or Rural Route Numi			ŕ
s 1 and 3 Health item 27 other tr	20	20a. Method of Dis	position		20b. P	lace of Dispo	sition (Name of natory or other place		Date		on - City or To	
Pages ment of I ant: If its ury or o			Cremation 3   5 Other (Spec		state	-			4-29-200	4 STEV	ENSVIL	LE, MD
permit. Pages 1 ar Department of Hea Important: If item any injury or othe		21. Signature of F	unera Service Lice	ensee ///	000	) 22 <b>F</b>	Name and Addres	ss of Facility	BEIN & NEV	NAM FO	NERAL	HOME PA
* 18		23a. Part 1. Enter	the disease, or cor	nplications that ca	used the death	2	00 S. HAI	RRISON	ST KASTON	MD 2		Approximate
Physician		shock, or hea	art failure. List onl (Final	one cause on ea	ach line.			C 1) .	,			Interval Between Onset and Death
/Medical		disease or condition resulting in death)		a. Con	or as a consequence		eart	Fai 10	re			60 Hours
ate be executed as yistician and he buriat-transit	icai Examiner	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death)	mmediate erlying rinjury s	b. Due to (c	perten dras a consequ or as a consequ	uence of):						20 years
ath certifica	by Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	months?		rth 2 ☐ Fetal ant at time of di	Ideath 3	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ory Day Year
wrequires that the de been signed by the a should be detached f		Part II. Other signi	ficant conditions	contributing to de	ath but not resi	ulting in the ur	derlying cause give	en in Part I.		_		e cause of death? ably 4 □Unknown
Physician: The law r this certificate has be al director, page 2 sh	Completed	Chron		structiv	e R	Imono	5 D	) isease			prior to cor death?	psy findings available inpletion of cause of
sician: The scorificate	o Be	25. Was case reference examiner?	_	Hospital:	Postiont 2	EB/Outpation	3 DOA Othe		Death (Check only		Oth (O	
anding Physiath. Or: After this he funeral di	-	27. Manner of Death 1 Activated 5 Pending investigation   28b. Time of Injury   28b. Tim										
Division of Attendia within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)										
Hosp 24 hou Fune stely fil	Medical	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exe	hysician: To the miner: On the ba and mann	sis of examinat	wledge, death tion and/or inv	occurred at the time estigation, in my op	ne, date and p pinion, death o	lace, and due to the occurred at the time	cause(s) and date and place	l manner as st ce, and due to	ated. the cause(s)
To the within To the Comple	Me	29b. Signature and	title of certifier	0			29c. License	number		29d. Date sig	ned (Month, I	Day, Year)
		)/n	with 1	Suci	L M	0		3253		4-2	6-04	
		30. Name and add	J. Sniez	ek Mi	0 1	36 Le	Inun Av	E PA	eston. M	0 2	1653	
Sta Registr		31. Date filed (Mor	DR 2 Q 200	8 832. Re	gistrar's Signa	ture			,			
DHMH 17 Rev 1/2	100	-200	~ 0 200	A State of	J.	Special	23	#1=011=====				
						ORIGINA	\L					

		1 - For State Registrar	State of Mai	ryland / Depa <i>Cel</i>	artment of Heartificate of De	alth and N eath		giene Reg. No.	200	4 1521
Physic /Medi		1. Decedent's Name (First, Middle, Las EDGAR FRE	t) DERICK	CARNEAL			2. Date of De Month May	Day 2	Year 20	
Exami Funeral Director		4a. Facility Name (If not institution, give MEMORIAL HOS 5. Social Security Number 220–20–2547	SPITAL	(In yrs. last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da DEC. 24	T	ALBO	
D.		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation		DEC. Z	1, 17	ZO HA	10d. Inside City Limits
Maryli -1 sho	tor	MD QUEEN A		CENTRE						1 □ Yes 2 No
th with the 23s or 28s	Funeral Director	10e. Street and Number 820 WRIGHTS NE			10f. Zip Code <b>216</b>	17		10g. Citize	of What C	country?
NOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene : if flem 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumatic event, the Madical Examiner must be notified at	þ	11. Marital Status  1 Never Mamied 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Armed Forces? 1 Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: W		Was Decedent of Hispa If Yes, specify Cuban, M 1 ☐ Yes 2 ♣ No S	nic Origin? (S) Nexican, Puerto opecify:	pecify Yes or No Rican, etc.)		4. Race - Am Black, Wh Specify:	erican Indian, ite, etc. WHITE
Z13-UU36 thin 72 hours aft e. an "natural, or Wedical Exern	Completed	15. Decedent's Ed (Specify only highest gra	de completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	ng most of won	king		d of Busines	,
C 212		17. Father's Name (First, Middle, Last)	-0-	DIS	TRICT MANAG		ne (First, Middle,		.P.OIL	
ylanc lould be f Mental P narked of	To Be	HORACE ELLSWOR	TH CARNEAL		10.	RUTH	CARROL		urriame)	
'e, Maryland 1 and 2 should be file Health and Mental Hy Iem 27 is marked oth ther traumatic event		19a. Informant's Name/Relationship (7		820 WI	ng Address (Street and RIGHTS NECK					
E Se Se Se Se Se Se Se Se Se Se Se Se Se		20a. Method of Disposition  1	)		sition (Name of natory or other place) ELD CEMETER	SY 5-6	Date -2004		ation - City o	r Town, State
DEMILL Pa permit. Pa Departmen Important: any injury		21. Signature of Pineral Service Licent	Helfenle	in 40	LLLOWS, HELF OS S. LIBER	ENBEIN TY ST.,	& NEWNA	M FUN	NERAL E, MD	HOME, P.A. 21617
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Sept	tic She	er the mode of dying, su	uch as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Examiner			1	consequence of):						1 week
D #	Iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying		eoneequanea of):						6 months
b& / bu, ficate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Gast	consequence of):	oncer					G F EN 9
death certifice attending of for use as	by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23	d. Date of de Month	olivery Day Year
r hat be deb		Part II. Other significant conditions of	entributing to death but	not resulting in the u	nderlying cause given in	Part I.			contribute t	o the cause of death?
The law ate has b	Completed					<del></del>			prior to death?	utopsy findings available completion of cause of s 2 \(\sigma\) No
OT VICAL Physician: T this certificate ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		Othor		th (Check only o			
ding Pl	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day )	2 ER/Outpatien  28b. Time of Injury	28c. Injury at Work?  M 1 \( \text{Yes}		ome 5 ☐ Resid			ecify)
in Eight	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and I vn, State)	Number or R	iural Route Number,
Lothe Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 Certifying Ph: (Check only one)	vsician: To the best of iner: On the basis of ea and manner state	xamination and/or inv	n occurred at the time, divestigation, in my opinio	ate and place, n, death occur	and due to the red at the time,	cause(s) ar date and p	nd manner a lace, and du	s stated. e to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier  30. Name and address of person who described to the second se	- MD	th (Item 23a) /Tuna	29c. License nur				signed (Mon	th, Dey, Year)
FKK		JORGE ABREGO, M.  31. Date filed (Month, Day, Year)		NWOOD DRI		04, EA	STON, MI	2160	01	
Regist	-		2004	me De p	(post)					

CARNEAL,

ORIGINAL

			for State	State of Maryla	ind / Depa	artment <i>rtificate</i>	of H	ealth a	nd M	ental Hy	giene Reg. No.	004	15218
			Registrar  1. Decedent's Name (First, Middle, Last)							2. Date of De			3. Time of Death
	Physici	an	Robert Chester DeS	hong						Month	Day 21	Year	6:10 P. M
	/Medio		4a. Facility Name (If not institution, give s			4h City T	own or	Location of	Death	April		2004 y of Death	6:10 P.
	Examir	ıer	13122 Pecktonville			Big			Doda			ingtor	2
			5. Social Security Number 6. Sex		s. last birthday)	If Under 1		If Under 2	24 Hrs.	8. Date of Bir			
v	Funeral Director			M 2□F	74 Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da	12,1929	PA	place (State or Foreign ntry)
	D.		Usual Residence of Decedent								, , , ,		
	death with the Maryland rms 23e or 28e-f show fust be notified at		10a. State 10b. County	10c. (	City, Town or Lo	cation						,	10d. Inside City Limits
	e Ma	Director	MD Washingt	on	Big Pool	<u>L</u>							1 ☐ Yes 2 No
	th th or 28	Oire	10e. Street and Number			10f. Zip (	Code				10g. Citizen of	What Cour	ntry?
	1h w	a	13122 Pecktonvil	le Road		21	711				USA		
	e de s	Funerai	11. Marital Status	<ol><li>Was Decedent Ever in Armed Forces?</li></ol>	U.S. 13.	Was Decede f Yes, speci	ent of Hi fy Cubai	spanic Orig n, Mexican,	in? (Spe Puerto F	cify Yes or No Rican, etc.)	- 14. Ra Bla	ce · Americ ck, White,	
36	or in	y F.	1 Never Married 2 Married	1 TotYes 2 ☐ No If Yes, Give		1 Yes 2	No.	Specify:			Speci	fy:	71
Ö	72 hours after natural', or ite	d by	3 Widowed 4 Divorced	Year or Dates:							101 101 115		White
5-	"nat	lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	tent's Usual kind of work DO NOT use	Occupa done d	luring most	of working	g	16b. Kind of E	usiness/in	austry
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Manylan stal Hygiene. od other than "natural", or flems 23e or 28e-f show svent, the Moorel Examiner must be notilised at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ection					State (	loverr	oment.
р 7	filed Hygi ther	Ö	17. Father's Name (First, Middle, Last)		JOSEF					(First, Middle,	Maiden Surna		
an	o pe	Be c	Chester DeShong					Me	alva	DeShor	10		
2	should be nd Mental marked umatic sv	10	19a. Informant's Name/Relationship (Ty)	ne. Print)	19b. Mailir	a Address	Street a				er, City or Town	. State. Zic	Code)
Ma	ges 1 and 2 should t of Health and Mer if Item 27 ie marke or other traumatic				1						ool, MI		
Ġ,	1 an Heal em 2		Janet D. DeShong/W	11E 20b	. Place of Dispo					T DTS T	20c. Location		
2	Pages nent of I int: if it		1 Derial 2 Cremation 3 R  1 Deriation 5 Other (Specify)	movai from State	arkhead				4/24	/04	Big Poo	.1 МТ	)
	그 문문을 .		21. Sonature Funeral Service Sicons	The state of the s		. Name and	-						
Ba	permi Depa Impo any i		12.0	TUXAA							1 West		street 1750-0368
	Physician /Medical Examiner  partial-transit	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	COUL	con	GTATI/ST		Pari	er tradi	Once	C ment
P.O. Box 68760,	ath certificate attending phy- for use as the	Physician/Medical E	IE EEMALE.	3c. If yes, outcome of prec 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	nancy	Ectopic pre						ate of delive	ery Day Year
	w requires that the de been signed by the s should be detached	þ	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying ca	use give	n in Part I.			obacco use con ⁄es 2□No	tribute to th	ne cause of death?
Vital Records,		Completed	<del>,</del>							24a. Was autop perfo	rmed?	Were autoprior to cordeath?	psy findings available impletion of cause of 2 No
ita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?						of Death	(Check only o	ne)		
Ž	hysik his ce I dire	5	1 ☐ Yes 2 ☐ No		☐ ER/Outpatien	t 3 🗆 DO A	Othe	4 Nurs	sing Hom	-	dence 6 🗆 Oth		y)
0	ng Pi		27. Manper of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury Work	at ?	2	8d. Describe h	ow injury occur	red	
0	uttendii death. ctor: A y the fu	ati	2 Accident investigation			М	1 🗆 Y	′es 2□N	lo				
Division of	or A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stri cify)	eet, factory,	office		2	8f. Location (\$ City or Tox		er or Rura	i Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	edicai		ician: To the best of my k er: On the basis of exami and manner stated.									
	To the To the Comp	ž	29b. Signatur and title of cartifier	W		29c.	License	number			29d. Date signe	d (Month, I	Day, Year)
)	,		Muy Ma	undi	an N	UI	SLA	64	13	• •	4/20/	04	
T	1		30. Nam and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print)	^	-	11		NI A		0 11
_			Hind Hamdo	M; MD; II	30 0	JAY	- (	10	3 H	degers	town,	M	21440
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2 200	32 degistrar's Sig	nature	and a	494		)	0	r		

			State of Maryland / Department  1 - State Registrar  Certificate		ental Hygie	•	15010
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Carolyn R Davi's	e or Death	2. Date of Death Month		Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)  College  5. Social Security Number  4b. City,  View Nursing Home  F1  7. Age (In yrs. last birthday)  If Unde	Town, or Location of Death Cederick r 1 Year   If Under 24 Hrs.	8. Date of Birth	4c. County of Death Frederic! 9. Birtholace	
	Director		213-44-4347  Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	Days Hours Min.	(Month, Day, Y	1916 Mary.	(State or Foreign  Land  Inside City Limits
	r 28a-f sho	Director	MD Frederick Frederick  10e. Street and Number 10f. Zig	ς Code	10g		1. Yes 2 □ No
9	2 should be filed within 72 hours after death with the Maryland and Manfal Hygiene.  is marked other than "naturel", or items 23a or 28a-f show sumetic event, If a Marjical Exaction must be notified at	Funeral	700 TOIL HOUSE DRIVE  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No	21701  dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	U.S.A.  14. Race - American In Black, White, etc.	ndian,
Maryland 21215-0036	hin 72 hours e. an "naturel", Medical Exp	Completed by	3 XWidowed 4 ☐ Divorced Year or Dates:		ng 16	b. Kind of Business/Industr	
land 21	illed Hygi other	0	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai tt Swai]		
e, Mary	and salth n 27 er tr		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	Saltimore Name of Do	atl Pike		vn, MD
Baltimore,	promit. Pages 1 spartment of He sportant: If iten ny injury or oth		'4 Donation 5 Other (Specify) Lincoln Par	ck Cem 4/30	)/2004 F	Rockville,	MD
ı	ă o s a a	4	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mos shock, or heaft failure. List only one cause on each line.	Washington	1 St Roc	ckville,MD App	20850 proximate erval Between set and Death
	/Medical Examiner	). (	disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	100			Day
68760,	icate be executed physician and s the burial-transit	dicai Examiner	d				
O. Box	The law requires that the death certifica lie has been signed by the atlending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic properties   5   Other (sp.			23d. Date of delivery Month Day	Year
Records, P.	w requires that s been signed b should be deta	ted by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.	23e. Did tobac	co use contribute to the ca	use of death?
tal Rec		e Completed by	Peripheral Vascular Disea  25. Was case referred to medical	S.C. 26. Place of Death	24a. Was an autopsy performed	24b. Were autopsy f prior to comple death? No 1 \( \text{Yes} \) 2 \( \text{I} \)	tion of cause of
Division of Vital	i or Attending Physicien: The favater dater death. Director: Attenthis certificate has in by the funeral director, page 2	Certification; To Be	examiner? 1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DO	Other: 4 Nursing Home 28c. Injury at Work? 1 Yes 2 No	ne 5 🗆 Residence 8d. Describe how i	injury occurred  It and Number or Rural Ro	ute Number,
	To the Hospitel or Ai within 24 hours after or To the Funeral Directompletely tilled in by	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	at the time, date and place, at, in my opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as stated and place, and due to the	cause(s)
	Tot. Withi	×	5tch Hiren	D51643		Date signed (Month, Day,	Year)
	Cho			redende	mD á	4702	
	Sta Registr		APR 2 8 2004 Jeneva 19 Apr	aks			

			1_ For		State of M	arylan				lealth and Death	d Mer	ital Hy	giene	20	) I.	15	221
			Registrar					unca	e or i	Dealli				. C U	J 4		2
Н	Physici		1. Decedent's Name (First August Fran									Date of De Month	Day	2004	reer	3. Time o	a M
	/Medio Examin		4a. Fecility Name (If not in					4b. Cily	, Town, a	Location of D		<i>,,,,</i> ,		County of	•	0.50	
	LXum	٠.	Springbroo	z Advor	ntiet Nur	S orig	Rahah		S113	er Spr	ino			Mont	ome:	rv	
	Funeral		Social Security Number	6. Se	x 7. A	ige (In yrs. I	ast birthday)		r 1 Year	If Under 24 h	Hrs. 8.	Date of Bir Month, Da	th			ece (State try)	or Foreign
	Director		212-09-1137	111	DM 2□F	87	Yrs.	Months	Days	Hours N		Feb.				yland	
	D		Usuel Residence of Deced														
	how how		10a. State 10b.	County		10c. City	, Town or Lo	cation							10	Od. Inside C	•
	a-f-s	cto	Maryland Mc	ntgome	ry	Si	lver S	pring	3							1 L Yes	2 🔯 No
	7 28 E	ire	10e. Street and Number		•			10f. Zi	p Code				10g. Cit	izen of Wh	at Coun	try?	
	72 hours after deeth with the Maryland natural, or items 23a or 28a-f show acal Examinar must be notified at	Funeral Director	10613 Shad	y Circ	:1e			2	0903				U	SA			
	98	ner	11. Marital Status		12. Was Deceder Armed Forces		S. 13.	Was Dece	edent of H	ispanic Origin? in, Mexican, Pi	? (Specify uerto Rica	Yes or No	)-	14. Race	Americ White,		
9	or its	<u> </u>	1 Never Married 2	Married	1 ☐ Yes 2 ☑ If Yes, Give			1 ☐ Yes		Specify:		,,		Specify:			
8	ours	d by	3 ₺ Widowed 4 □ D	vorced	Year or Dates	:				y.				арвену.	W 11 T C		
2	72 h natu	Completed	15. D (Specify only	cedent's Edu highest grad	ication le completed)		16a. Dece (Give	dent's Usu kind of w	al Occup	ation during most of d)	working		16b. K	ind of Busi	ness/Ind	lustry	
21215-0036	within ene. then "	idn	Elementary/Secondary	0-12)	College (1-4o	r 5+)											
2	ygier ygier t.	S	12				Own	ner/	Oper		N /F					ation	
Maryland	be fill tai H dot!	Be	17. Father's Name (First,	niddie, Last)						18. Mother's	_		_		,		
<u>8</u>	Men Men arke	ို	Frank DeL	_								ondo1					
<u>a</u>	2 sh and is m		19a. Informant's Name/Re							and Number or			-				123
2	s 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. I the Marylan term 21 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Marylan Experiment mant be notified at		Frank C. De		Sr./ Son	201 5	-			briar P		ay, Si			_		903-
ore	of H		20a. Method of Disposition 1 XBurial 2 Crer		Removal from Stat	_   0	lace of Dispo emetery, crea	matory or	other place	(e)	Date	26		ocation - C			
Ě	permit. Peges 1 Department of H Importent: If its any injury or ot		4 Donation 5			Gar	te of Ceme	Heave	en	Ap	2004	20 ,	Sil	ver S	ori	ıg, MD	8
Baltimore,	permit. Departr Import any inj		21. Signature of Funeral S	ervice Licens	100		2: F-	2. Name a	nd Addre	ss of Facility Collin	e Fu	neral	Чоп	ne In	C		
<b>m</b>	89 = 89		Cober	72K	ams	es	150	JŪ Un	iver	sity B1	Lvd.	W., S	ilve	er Spr	ing	, MD 2	0901
7		- 1	23a. Part1. Enter the dise shock, or heart failu	ase, or comple	lications that caus	ed the leath	n. Do not en	er the mo	de of dyin	g, such as car	diac or re	spiratory a	rrest,			Approxima Interval Be	te tween
	Physician		Immediate Cause (Final	o. cist only o											T.4	Onset and	Death
	/Medical		disease or condition resulting in death)	-	a. Sepsis	is a consequ	ience of):									1 We	<del>≥k</del>
	Examiner			- 1	Pneumor		.,,,,								T	ess t	han
À	A 2	er	Sequentially list condition if any, leading to immedia cause. Enter Underlying	te l	U	is a consequ	ionea of):										eek
	be executed sician and burial-transit	Examiner	Cause (Disease or injury	1													
_^	be execu ician and burial-tra	xa	that initiated events resulting in death) Last		c. Due to (or a	ıs a consequ	uence of):										
	sicial buri	<u>a</u>			d												
687	ficate phy: s the	dic			u												
×	death certificate I e attending physi d for use as the t	by Physician/Medic	IF FEMALE: 23b. Was decedent pregr	201	23c. If yes, outcom								- 1	23d. Date	of delive	rv	
Вох	atter for u	ciar	in the past 12 month		1 ☐ Live birth 4 ☐ Pregnant			∃Ectopic p ∃ Other (s						Monti		Day	Year
	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	}	9□ Unknown												
٥.	requires that the di een signed by the hould be detached	P.	Part II. Other significant	onditions co	ntributing to death	but not resu	ulting in the u	nderlying	cause giv	en in Part I.		23e. Did t	obacco u	use contrib	ute to th	e cause of	death?
ds,	uires that signed b d be det		End Stage R	anal D	100200							1 🗆 `	Yes 2	⊠No 3	☐ Proba	abiy 4 🗆	Unknown
0		ompieted	Lind brage it	cnar D.	ISCASC									1		-	III.
Records,	2 5	npi										24a. Was autor	psv	Dri	or to con	sy findings apletion of	cause of
-	Th ate pag	ပ္ပ										1 Yes	ormed? 2⊠ No	1 [	ath? ] Yes	2 🗆 No	
Vital	Physicien: Th this certificate rai director, pag	Be	25. Was case referred to examiner?							26. Place of	Death (C	neck only o	one)				
of C	Physic this co	2	1 ☐ Yes 2 🔯 No		Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatie			4 M lantain	ng Home	5 🗌 Resid	dence	6 Other	(Specify	)	
		:ic	27. Manner of Death 1 X Natural 5 □	Pending	28a. Date of In (Month, E	jury Day Year)	28b. Time o	f	28c. Injur Wor	y at k?	28d.	Describe I	how injur	y occurred	1		
0	Attending r death. ector: After by the fune	atle	2 Accidant	investigation				М	1 🗆	Yes 2 ☐ No							
Division	of or Attendation of after death in Director:	tific	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of I building,	njury - At ho	me, farm, st	reet, facto	ry, office		28f.	Location (: City or Tox			or Rural	Route Nur	nber,
	tel or rs afte el Dir ed in	Certification:			1											- 7 . 70 . 67	
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by		29a. Certifier 1 ☑ C	ertifying Phy edical Exam	rsician: To the bei	of examinat	wiedge, deat	h occurred	d at the tir n, in my o	ne, date and pl pinion, death o	lace, and	due to the	cause(s)	and manr	ner as sta d due to	ated. the cause(	s)
	the Fin 24 the Fithe Figure 19	Medicai	one)		and manner	stated.											
	To the To the compl	2	29b. Signature and title of		K. 7	c. ().	۳	29	c. Licens	e number			29d. Dat	te signed (	Month, L	Jay, Year)	
7	12		> 1ce	mai	11	JUL!		H	717	507.			Apri	1 23	, 20	04	
	,		30. Name and ad ess of	person who o	ompleted cause o	death (Item	23a) (Type,	Print)									
			Raman R. T		D. 108	310 Da	rnest	own R	oad,	Suite	202,	Gait	hers	burg	, MD	2087	8
	Sta		31. Date filed (Month, Da			trar's Signa	ture A	Lo	aks	/							
	Regist		1/2/2	2 5 2NE	PER L L STOPA		~	1290									

			For State Registrar	State of Maryla		artment of I <i>rtificate of</i>				ene 20	04	15221
	di.	Q.	Decedent's Name (First, Middle, Last)	)					ate of Death			3. Time of Death
	Physici /Medic	al	Victor Simon Deski			4b. City, Town,	or Location	Apı	ril 23	,	Year f Death	11:15pm
	Examir	er	Shady Grove Advent 5. Social Security Number 6. Sep	ist Hospital	s. last birthday)	Rockvil	1e		ate of Birth	Montog	mery	ing (State or Foreign
die.	Funeral Director			M 2□F 52	Yrs.	Months Days		Min. (N	ate of Birth fonth, Day, Y rch 19,	, 1952 V	Country Vashi	ngton, DC
	land ow		10a. State 10b. County	10c. C	City, Town or Lo	ocation			·		100	d. Inside City Limits
	8a-f eh	Director	Maryland Montgome	ry Ro	ckville				100	. Citizen of Wh		1x Yes 2 No
	with ti	吉	10e. Street and Number			10f. Zip Code						
	leath ns 23	Funerai	804 Maple Avenue	12. Was Decedent Ever in	U.S. 13.	20850 Was Decedent of If Yes, specify Cut	Hispanic O	rigin? (Specify Y			- American	n Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than *natural; or items 23a or 28a-f ehow other than *natural; or items 23a or 28a-f ehow event, it is Medical Examinat mast be redified at		1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	If Yes, specify Cut 1 ☐ Yes 2🛛 No			, etc.)	Specify:	, White, et	
9	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation	net of working	16	5b. Kind of Bus		
Maryland 21215-0036	e filed within 7 al Hygiene. other than "n	Completed by	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	ad/ing mo ad)	ist of working		Automo	hile	
<b>d</b> 2	Hygie hygie other		17. Father's Name (First, Middle, Last)		Бате	Sman	18. Moth	her's Name (Firs	t, Middle, Ma			
an	should be fand Mental 8 marked of	To Be	Martin Deskin				Marg	garet Ho	1man			
ary	2 should be and Menta le marked aumatic ev		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (Stree	t and Num	ber or Rural Rou	te Number, (	City or Town, S	tate, Zip C	ode)
	1 and 2 Health em 27		Margaret Deskin	(mother)		Maple Ave	nue,		-			
Baltimore,	S to to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crei	matory or other pla		Date		Oc. Location - C		
Him	permit. Page Department of Important: If any injury or any injury or		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	Re	sthaver	Cemeter  Name and Addr	ss of Faci	4/28/20 lity DeVol	04 Fr Funer	rederic. ral Home	k, Ma e	ryland
Ba	Departing Departing Important in any in 2000		of the the	Steff	10 Ga	2.Name and Addr ) East De aithersbu	er Pa	rk Driv 10 20877	е			
42			23a. Part Enter the disease or compleshock, or heart failure. List only or	ications that caused the de ne cause on each line.	ath. Do not en	ter the mode of dy	ing, such a	s cardiac or resp	piratory arres	t,	li d	Approximate nterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Intracrani		norage						4 Hours
	/Medical Examiner			Due to (or as a conse	equence of):							
	9	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equanna of):					-		
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
68760,	ficate be executed physician and is the burial-transit	a Ex	resulting in death) Last	Due to (or as a conse	equence of);							
687	ificate g phys as the	edical		d								
O. Box	at the death certific by the attending p tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death 3	Ectopic pregnanc Other (specify)	;y			23d. Date Mont	of delivery h D	/ Day Year
P.0	that the	by Ph	Part II. Other significent conditions con	ntributing to death but not re	esulting in the u	nderlying cause g	ven in Parl	11. 2	3e. Did toba	cco use contrib	oute to the	cause of death?
rds	en signe								1 🗆 Yes	2 🔼 No 3	Probab	biy 4 🗀 Unknown
Records,	The law requires that the ate has been signed by th page 2 should be detache	Completed						2	4a. Was an autopsy performe	pri	ere autops or to comp ath?	sy findings available pletion of cause of
a	ician: The l certificate ha rector, page		U.S. When some referred to madical				00 Bl-		☐ Yes 2X			□ No
Vital		To Be	25. Was case reterred to medical examiner?  1 Yes 2X No	Hospital: MInpatient 2	□ EB/Outpatier	nt 3 DOA O	hor	ce of Death (Che Jursing Home 5		ce 6 □Other	(Specify)	
on of	fter fter neur		27. Manner of Death 1 ♣ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju		28d. C		injury occurred	1 77	
Division	I or Attending after death. Director: After in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe-	home, farm, str cify)	reet, factory, office		28f. Lc	ocation (Stre lity or Town,	et and Number State)	or Rural F	Route Number,
_	To the Hospital of within 24 hours at To the Funeral D completely filled in			sician: To the best of my kiner: On the basis of exami								
	the h	Medical	29b. Signature and title of certifier	and manner stated.			se number			1. Date signed		
	3 3 5 8		250. Signature of Continuity					7581				1455
	>		30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type,			001	2	, ,,,	0 4	,,,,,
70.000			Mark Miller, MD 16				ither	sburg,	MD 208	379		
A.	Sta Regist		31. Date filed (Month, Day, Year) APR 2 7 20	32. Registrar's Sig		Space	21					

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Wyatt 12:28P<sup>™</sup> Lorine Douglas April 24, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4 Pinecrest Court Greenbelt Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 27, 1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2√F 92 Yrs. Director 032-12-8347 Kentucky Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Kentucky McCracken Paducah Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3587 Clinton Road 42001 United States permit. Pages 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Importment: If item 27 is marked other than "naturer; or items 23s eray injury or other traumatic event; It a Medical Exaction in a final and once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Clint Wyatt Ruth Owsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Larkin -Daughter 4 Pinecrest Court Greenbelt, Maryland 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Pleasant Cemetery 4/29/2004 Puryear, Tennessee 14 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A 21. Signature of Funeral Service Lig 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Metastatic Oropharyngeal Carcinoma 1 year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2□XNo or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other Part Item's Hore 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) within 24 hours a
To the Funerel I
completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pavid Prante, 000 117572 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 Centerway Greenbelt, 813 20770 D. Oranite, 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Deneva Registrar

			For State of Maryla	and / Depa <i>Cel</i>	artment of Health and Natificate of Death		ne2004	15223
	9		1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	°Physicia /Medic		Genevieve Joan Drew			April 2	2, 2004	10:05 PM
*	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Deat	th
51.	*;		3221 Regina Drive		Silver Spring		Montgor	
	Funeral		1 □ M 2 □ X E	rs. last birthday) - Yrs.	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	ear) Co	hplace (State or Foreign ountry)
ŀ.	Director		215-36-3393 66	) 113.		Feb. 21,	1938   11	linois
	/land			City, Town or Lo	ocation			10d. Inside City Limits
	Mar a-fah	tor	Maryland Montgomery S	ilver S	pring			1 ☐ Yes 2 🔯 No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	ountry?
	23E		3221 Regina Drive		20906		USA	
	er dek	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
50	rs aft	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 No Specify:		Specify: Whi	te
ş	should be liled within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or Itams 23s or 28a-f ahow umatic avant. It a Modical Examination is the molithed at	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16	b. Kind of Business/	Industry
213	hin 73	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during most of work DO NOT use retired)	ing		
7	ad wit	Con	12	Sec	cretary		Clerical	-
Maryland 21215-0036	be filk tal Hy d oth avant	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma.		
<u> </u>	ould Men Marke Maric	٩	Carl H. Roeder	1		. Templin		
200	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rur			
	1 and Health am 27 ther ti		Barrington Drew/ Husband  20a. Method of Disposition 20b	. Place of Dispo	Regina Drive, Sil		Location - City or	
ğ	Pages nent of ant: If it ary or o			arklawn	Memorial Apr	11 27,		
Baltimore,	artme ortan injuri		21. Signature of Funeral Service Licensee	Pa	rk 2. Name and Address of Facility	2004 <u>R</u> 0	ockville,	Maryland
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic and DEE.		1 Kar Stile		ancis J. Collins O University Blvd			o MD 20901
ľ	. 0		23a. P. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.					Approximate Interval Between
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	/Medical		disease or condition resulting in death)  aCard1opula:  Due to (or as a cons	sequence of):	rrest			4 4
	Examiner				ic Squamous Cell (	Cancer		
	be iis	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):				
	xecut and II-tran	Examiner	that initiated events resulting in death) Last  C	sequence of):				
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89	ificate g phy as the	edlo	U					
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ F		∃Ectopic pregnancy		23d. Date of del	,
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	res that igned b	by	Part II. Other significant conditions contributing to death but not					the cause of death?
ecords,	w require been si should?	eted	Chronic Obstructive Pulmonary	Diseas	e		1	
Rec	The law cate has b page 2 s	Completed				24a. Was an autopsy performe	prior to d	stopsy findings available completion of cause of
						1 ☐ Yes 2 🛭		2 No
Vital	sician: certifica irector,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2	! ☐ ER/Outpatier	Othor	h (Check only one)		- 4 )
o	Phys or this oral dii	-	27. Manner of Death  1 ⊠ Natural 5 □ Pending (Month, Day Year,		f 28c. Injury at	28d. Describe how	e 6 Other (Specinjury occurred	city)
on	nding P ath. r: After t e funera	ation	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of	if or Attendi after death. Diractor: A d in by the fu	iffica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office	28f. Location (Stree City or Town, S	at and Number or Ru	ıral Route Number,
$\bar{\Box}$	tal or	Certification:	ballallig stor (ep.		N.			10
	To the Hospital or Attending Physician: within 24 hours after death.  To tha Funaral Diractor: After this certific completely filled in by the funeral director.		29a. Certifier (Check only (Check only 2 Medicel Exeminer: On the basis of exam	knowledge, deat	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the caus	e(s) and manner as	stated. to the cause(s)
	Fo the H within 24 Fo tha S complete	Medical	one) and manner stated.		29c. License number			
	To To Cor	~	29b. Signature and title of certifier				Date signed (Monti	
ľ	10		20 Name and address of account the second state of the first	tom (20a) (75	D30186		April 26,	2004
			30. Name and address of person who completed cause of death (I Asim Amin M.D. 3800 Reserv		ad, NW, Washington	. DC 2000	7-2113	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature 33.	gnature /	1	, 23 2000		
	Registi		APR 2 7 2004 Some	19	Sparks			

		055	1 - For State Registrar	State of Mar	yland / Depa		lealth and M	Mental Hygier	ne 2001	15221
	Physic /Medi		Decedent's Name (First, Middle, Last)  JASON	LEE	DUN	HAM		2. Date of Death Month I	Day Year 2004	3. Time of Death 4:42 P M
	Examir	ner	4a. Facility Name (If not institution, give s  NATIONAL NAVAL N  5. Social Security Number 6. Sex	MEDICAL CE		in .	BETHESDA  If Under 24 Hrs.		4c. County of Death  MONTGOME	
	Funeral Director			M 2□F	In yrs. last birthday) 22 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea NOV. 10, 1	9. Birthol Coun 981 NEW	ace (State or Foreign try) YORK
	with the Maryland B or 28a-f show by nuilified at	Director	NY ALLEGAN  10e. Street and Number	Y	Oc. City, Town or Lo	ALLEGANY		10g. (	Citizen of What Count	Od. Inside City Limits  Yes 2 No  try?
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "natural", or flema 23a or 28a-1 show event, the Mcdical Exatribut huntilled at	ted by Funeral Director	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced  15. Decedent's Educ	REEK RD.  12. Was Decedent Even Armed Forces?  1 X Yes 2 No If Yes, Give Year or Date 200 cation	00-2004	Was Decedent of Information of Yes, specify Cub  1 ☐ Yes 2X No	pation	16h	U.S.A.  14. Race - America Black, White, e  Specify: WHIT	re. re
21215		Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2	completed) College (1-4or 5+)	(Give life.	DO NOT use retire	during most of worki d) MARINE	ing	DEFENSE	
Maryland	should be filed within nd Mental Hygiene. I marked other than umatic event, the Men	To Be (	17. Father's Name (First, Middle, Last)  DANIEL	K. DUNH	AM			e (First, Middle, Maide NATALIE J	en Sumame) EAN WALKI	ER
	1 and 2 s Health ar em 27 is		DANIEL K. DUNHA  20a. Method of Disposition	M/FATHER	3857 20b. Place of Dispo	KNIGHTS	CREEK RD	al Route Number, City  ALLEGAN Date 20c.		30
Baltimore,	permit. Pages Department of H important: If its any injury or of		1 XBurial 2 Cremation 3 Re  1 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Liver se	e A A	FAIRLAWN	CEMETERY	5-1-2	2004 S OME & CREM	CIO, NY	. A .
50,	hysician and hysician and Examiner.	l Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	PENETRATI  Due to (or as a c	e death. Do not entered to the consequence of a consequen	er the mode of dyir	ng, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
.O. Box 68760,	death certific e attending p d for use as i	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery	y Day Year
0	The law requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions cont	tributing to death but n	ot resulting in the un	iderlying cause giv	en in Part I.	23e. Did tobacco	use contribute to the	cause of death?
Il Records,	The law recate has be page 2 sho	Completed						24a. Was an autopsy performed?	prior to com- death?	sy findings available pletion of cause of
Division of Vital	or Attending Physician: The Is after death. Director: After this certificate ha in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner?  1 Styles 2 No Ho  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Momicide Getermined	ospital:  28a. Date of Injury (Month, Day Ye  APR 14 2  28e. Place of Injury building, etc. (S	.004 1220 At home, farm, stre Specify)	28c. Injun Work	y at k?? Yes 2 \(\sum \) No	(Check only one)  ne 5  Residence 18d. Describe how inju  DURING 18f. Location (Street a City or Town, State	6 Other (Specify) uny occurred  MILITARY ( nd Number or Rural I	OPERATIONS .
	Hospital 24 hours Funeral stely filled	edical Ce	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	BATTLE ician: To the best of mer: On the basis of example and manner stated	ny knowledge, death amination and/or inv	occurred at the timestigation, in my of	ne, date and place, a	AL ANBAR P and due to the cause(s and at the time, date an	s) and manner as stat	ted. he cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier  30. Name and address of person who con	Dup	2	29c. License (NY) Print) ARME	227359		RIL 23, 20	004
	Sta Registr		DZUY TAN NGUYEN, 31. Date filed (Month, Day, Year) APR 2.7 2007	32. Registrar's			RESEARCH	BLVD., RO		

DRVH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#5,QACHD, State of Maryland / Department of Health and Mental Hygiene per inf,5/6 to 4,kk Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician ROBERTA M. DOAK 4:30 AM APRIL 28 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNAPOLITAN ASSISTED LIVING ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 5 390 40- 1480 1 □ M 2 K F APR. 29, 1923 Director 80 KENTÚCKY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 ▼ No Directo MD QUEEN ANNE'S GRASONVILLE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WIT 1115 OYSTER COVE DRIVE 21638 **USA** Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗶 No WHITE Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than other traumalic event, it was Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT CLARK ALPHA PINKSTON ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1115 OYSTER COVE DR., GRASONVILLE, MD 21638 ROBERT DOAK/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 04/29/2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

sician edical

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed

23a Part I. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are cause on each line.  Baranoil Schize planne.	est, Approximate Interval Between Onset and Death
resulting in death)	Due to (or as a consequence of):  Lypertensian	meay yy
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Denue to (or as a consequence of):	meny 4 r.
	d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions o	_, 3	pacco use contribute to the cause of death? es 2,⊠No 3 □ Probably 4 □Unknown
	24a, Was autop perfor	y prior to completion of cause of
25. Was case referred to medical examiner?	26. Place of Death (Check only or	θ)
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Resid	ence 6 Other (Specify) ACE
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of lnjury  28c. Injury at Work?  1  Yes 2 No	ow injury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (S City or Tow	reet and Number or Rural Route Number, n, State)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	visician: To the best of my knowledge, death occurred at the time, date and place, and due to the ciner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, cand manner stated.	ause(s) and manner as stated. ate and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number Type 40519	9d. Date signed (Month, Day, Year)

CLH Stat

DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day, Year)
Registrar APR 2





ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Group: Crofton, mo 21114

			1 - For State Registrar	State of I	Marylaı	nd / Depa	artmen rtificate	t of H	ealth a	and M	ental Hy	giene Reg. No. 20	04	15226
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last,     Lorraine A. Pink     A. Facility Name (If not institution, give Dorchester General)	Evans				Town, or	Location of		2. Date of De Month April	24 24 4c. County Do	Year OOH of Death rches	
	Funeral Director		5. Social Security Number 6. Set 220-46-4797	7. M 2 <b>M</b> F	Age (In yrs 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi April 1	<sup>rth</sup> 2, Year 1917	9. Birth	place (State or Foreign intry-York
5	n the Maryland or 28a-f ahow e notified at	irector	10a. State 10b. County  Maryland Dorches  10e. Street and Number	ster	10c. C	ity, Town or Lo	ambric 101. Zip	Code				10g. Citizen of		10d. Inside City Limits 1 ☐ Yes 2 No intry?
38 Se	72 hours atter death with the Maryland hineturel', or Itams 23a or 28a-f show dical Examiner must be notilised at	by Funeral Director	8 Chelsea Drive  11. Marital Status  1 Never Married 2 Married  3 Married 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? No		Was Deced If Yes, spec	lent of Hi	spanic Ori n, Mexicar Specify:		cify Yes or No Rican, etc.)	USA  14. Rac Bla  Specif	ck, White,	
12	within ene. then *	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation		16a. Decec (Give life.	dent's Usua kind of wor DO NOT us Homen	k done d e retired	luring mos )	t of workin	ng	16b. Kind of B	usiness/lr	1te ndustry
ryland	Mer Mer	To Be C	17. Father's Name (First, Middle, Last)  Clarence E. Pink  19a. Informant's Name/Relationship (Ty	rpe. Print)		19b. Mailir	ng Address	(Street a	Ju	lia N	Nuding	n, Maiden Surnar ner, City or Town		o Codel
	es 1 and 2 of Health a f item 27 is r other tra		Edward N. Evans, 1  20a. Method of Disposition  12 Burial 2 Cremation 3	II/Son	20b.	131 Place of Dispo cemetery, cren	7 Reg	gatta ne of ther place	a Dr.	, Wil	Lmingto	on, NC 20c. Location	2840. City or T	5 own, State
Baltimore,	permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (Specify)  21. Superfure of Funeral Fixed License  ALLE 0 0 1 777 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	to the	1010 Herri	d Trini						Church Home, P MD 216		ek, MD
	Physician /Medical Examiner		23a Part. Enter the disease or complished, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	Prec		th. Do not ent	er the mode	e of dying		cardiac or				Approximate Interval Between Onset and Death 5 clarts
,160,	ite be executed lysician and ne burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or Due to (or										
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ords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death	but not re	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	_		he cause of death?
		Completed									1 ☐ Yes	psy prmed? 22No	Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
ō	Phys rat di	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of J		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r: 4□Nu	rsing Hom		one) dence 6 □Oth how injury occur		(y)
Division	Hospital or Attending 4 hours after death. Funerel Director: After tely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building,	etc. (Speci						City or To	wn, State)		al Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 2 Medical Examinate one)	sician: To the be ner: On the basis and manner	of examin	owledge, death ation and/or inv	vestigation,	in my op	inion, dea	d place, a th occurre	nd due to the d at the time,	cause(s) and ma date and place, 29d. Date signe	and due to	o the cause(s)
	Mei TO CO		29b. Signature and title of certifier  30. Name a / ad/ ess of person who co	ompleted cause of	if death (Ite	m 23a) (Tvpe	1	)20	638			April		
	Sta Registi		Michael T Free 31. Date filed (Month Day, Year) 20	Elen M.	∆ 30. strar's Sign	a colli	rts /	/fur	lock	MD	2144	43	<del></del>	

		1- State of Maryland Registrar	d / Depa		lealth and M		_	
Physic		1. Decedent's Name (First, Middle, Last)  Dorothy Poist Farm	er			2. Date of Death Month April		ear 004 6:30 p M
/Medi Examii		4a. Facility Name (If not institution, give street and number)  Residence: 1568 Hopewell Road			Location of Death Deposit		4c. County of	
Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. la</i> 220−22−6950 1 □ M 2∑F 76	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Oct. 5,	'ear) 9	Birthplace (State or Foreign Country) Maryland
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City,  Maryland Cecil	Town or Lo		eposit			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the 23a or 28a	al Direc	10e. Street and Number 1568 Hopewell Road		10f. Zip Code	1904	10g	. Citizen of Wha	st Country?
1713-19-UU30 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Evarainer must be invitibled at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 Yes 2 Who If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
Z I Z I 5-UU36 ad within 72 hours aff gione. er than "natural", or the Medical Erain.	mpleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. l	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of work )	At		Proving Groun
Maryland 2. nd 2 should be filed v lth and Mental Hygie 27 Is marked other t rtraumatic event, III	To Be Co	Twelve Years  17. Father's Name (First, Middle, Last)  George Washington Pois		Inistrati	18. Mother's Name	ant Ab (First, Middle, Ma rian H. K	iden Sumame)	Maryland
		19a. Informant's Name/Relationship (Type, Print) Delmar Farmer (husband)	19b. Mailir 1568		Road, Po	al Route Number, C rt Deposi	City or Town, Sta	ite, Zip Code)
Kalilmore, perril. Pages 1 a Department of Hes Important: If item any injury or othe			pewe11	Cemeter	y 04/3 s of Facility	0/04 Po	ort Depo	osit, Maryland
D & B E E &		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Do not ente	Perryville er the mode of dying	e, <u>Maryla</u> g, such as cardiac c		3 <del>-0766</del> —	Approximate Interval Between Onset and Death
ate be executed  This puritification and the burial-transit the burial	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cons	ence of):	LUN	/G			241.
is, r.C. box 60/00, es that the death certificate be executed igned by the attending physician and be delached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	leath 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
w requires that i been signed by	by	Part II. Dther significent conditions contributing to death but not result  Oit 120 N1 C PULMONA!  Other Significent conditions contributing to death but not result  Oit 120 N1 C PULMONA!	ing in the ur	nderlying cause give	n in Part I.	-		te to the cause of death?  Probably 4 Unknown
The law recate has been page 2 sho	Completed	CHRENIC LYMPHOCY	71C	LEUKE.	MIA	24a. Was an autopsy performed	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sumbole\) No
To the Hoapital or Attending Phyaician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ation; To Be	25. Was case referred to medical syaminer?  1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Accident  1 ☑ Pending 2 ☐ Accident  1 ☐ Inpatient 2 ☐ Element 2	R/Outpatien 8b. Time of Injury	28c. Injury Work	at 2	(Check only one) ne 5 🔀 Residence 28d. Describe how		Specify)
DIVIS  Dital or Atte  urs after de  ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)				City or Town, S	itate)	r Rural Route Number,
To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b.	Medical	29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the best of my knowl and manner stated.  2 ☐ Medicel Exeminer: On the basis of examination and manner stated.	edge, death n and/or inv	estigation, in my op	inion, death occurre	ed at the time, date	and place, and	r as stated. due to the cause(s)
F 3 F ŏ		Illulugmy M.D.	•	D-19	5994	9	129/0	4
D	te	30. Name and address of person who completed cause of death (Item 2 LETICIA 5 - GAL VEZ M.D.  31. Date filed (Month, Day, Year)  APR 2 9 2004  Registrar's Signatu	· 63	25 5, W.	NION AV	E. HAU.	RE PE	21078
Registi	ar	APR 2 9 2004	A CO					

RKD			1 - For Unpend Item i	28tate-pf 28	ary ar	nd/Depa per ine Ce	argent eff	ilealth a Death	nd M tas	lental Hy	giene 2	004	152	228	
			Decedent's Name (First, Middle, La.			-			-	2. Date of De	ath		3. Time of	Death	
	Physici /Medic		Patr	ick James	Fish	n			i	Month APRIL	30 <b>,</b>	2004	2:18P	М	
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of	f Death			unty of Deatl	h		
9			HARFORD MEMORIAL				HAVRE o					RFORD			
3606	Funeral Director		070-00-4932	ex 7. Ag	ge (In yrs. 27	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da Jan. 9	th ly, Year) 1977	9. Birth Con N	opface (State o untry) ew York	r Foreign	
. ,—	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside Cit	ty Limits	
	d 2 should be filed within 72 hours after death with tha Maryland th and Mental Hygiene. It and Mental Hygiene. 77 is marked other then "natural; or itams 23e or 28a-f show treumatic event, it a Modral Examinating to indiffed at	ţ		cil		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Perryv	ille					1 ☐ Yes		
	th tha	Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Co	untry?		
	ath wi	raic	27 White Oak Dri					1903				U.S.A			
	er de:	Funeral	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀	,	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Orig an, Mexican,	jin? (Spe , Puerto l	cify Yes or No Rican, etc.)	14.	Race - Amei Black, White			
21215-0036	urs aft	by	1 ☐ Never Married 2 💆 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 ☑ No	Specify:			Spe	ecity:	White		
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	fucation de completed)		16a. Dece	dent's Usual Occu	oation	of workin	) <i>G</i>	16b. Kind o	of Business/I	ndustry		
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Marvland	ld ba ental kad o	To Be		Martin F	ish			101 10101101	o manio		Ellen				
2	shou and M a mar umat	_	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailir	ng Address (Street	and Number	r or Rura				ip Code)		
	and 2 alth a 27 is		Sheri M. Fish (w	ife)		27 W	Thite Oak	Drive	e, Pe	erryvil	le, Ma	rylan	d 2190	3	
ore	of He of He If item or oth									ate	20c. Location	on - City or 1	own, State		
Baltimore,	Pag tment tent: jury c		`4 □Donation 5 □ Other (Specify	<i>'</i> )	R.									ania	
Ba	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tree		1. Signature of Funeral Service Licensee  1. Signature of Funeral Service Licensee  1. Patterson & Perryville, Marylan					Son Fund 21	neral 903-07	Home,	P.A.				
_	79		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each fir	the deat	h. Do not ent	er the mode of dyi	ng, such as c	ardiac o	r respiratory ar	rest,	3-0/66			
	Physician . /Medical		Immediate Cause (Finaf disease or condition resulting in death)	a. Heroin			on						Offiset and D	eatri	
raw	Examiner			Due to (or as	a conseq	uence of):									
44		Jer	Sequentially list conditions,	Sequentially list conditions, any leading to forme an ounsequance of):  Due to (or se a ounsequance of):  ause. Enter Underlying cause (Disease or injury											
	Hospital or Attending Physicien: The law requires that the death certificata be exacuted yt hours after death. Funeral Director: After this certificate has been signad by the attending physician and telly filled in by tha funeral director, page 2 should be detached for use as the burial-transit	Examiner	that initiated events	c											
8760,	oe exa	i Ex	resulting in death) Last												
928	cata b physic	Physician/Medical		d											
9 X	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	incy					224	Date of deliv			
Вох	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 □ Live birth 4 □ Pregnant at	2 Feta	fdeath 3	Ectopic pregnanc Other (specify)	<i>f</i>				Month	-	ear	
P.O.	that the de ad by the dedechad	hys	9 □ Unknown	9□ Unknown											
	res that ignard be de	by	Part II. Other significant conditions of	ontributing to death be	ut not res	ulting in the ur	nderlying cause giv	en in Part I.					the cause of de	1	
Division of Vital Records,	w requir been s should	Completed								1 U Y	′es 2 □ No	3 🗆 Pro	bably 4 DU	nknown	
ec	elaw hasb je 2 si	nple								24a. Was autop	sy	prior to or	opsy findings a ompletion of ca	vailable use of	
a E	n: The licate ha										rmed? 2 No	death?	2 No		
Vit.	sicien: 'certifica	o Be	25. Was case referred to medical examiner?  1X Yes 2 \( \subseteq \) No	Hospital: 1 ☐ Inpatie	257	FB/Outpation	3 000 Ott			Check onl of		-		-	
ō	ding Phys h. After this tuneral did	n: To	27. Manner of Death	28a. Date of Injur	rv i	ER/Outpatien 28b. Time of	28c. Injur	4 114013		e 5 🗆 Resid			fy)		
io	Attending death. ctor: Aft y tha fun	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	For Month, Day 4/30/200	)4	Found		k? Yes 2. 🙀 Ne	° U	nknown					
<u> </u>	of or Attencater death Director:	Certification:	3 ☐ Suicide 6 ★ Could not be determined	28e. Place of Injubuilding, etc			et, factory, office				treet and Ny	7 Whit	e Vak	Örive	
Q	spitel or Al ours after o terel Direc filled in by			Residenc	ce				P	erryvi	lle, M	d			
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai	29a. Certifier 1 Certifying Phyone) Medical Exam	ysician: To the best of liner: On the basis of and manner sta	f examina	wledge, death tion and/or inv	occurred at the tirestigation, in my c	ne, date and pinion, death	place, ar occurre	nd due to the o d at the time, o	ause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)		
_	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier				29c. Licens	e number		2	29d. Date sig	ned (Month,	Day, Year)		
			> Unest				0.0	C.M.E.		N	AY 1,	2004			
_	Ø		30. Name and address of person who o			23a) (Type, I									
-			31. Date filed (Month, Day, Year)	310, M.			111 Penn	Stree	t, B	altimon	re, Ma	ryland	21201		
	Sta Registra		MAY 4 2004	32. Registra	_	ture									

			1 - For State Registrer	ate of Maryland / Dep Ce	ertificate of L			giene 2	004	15229
	3	7	Decedent's Name (First, Middle, Last)				2. Date of Dea Month		Year	3. Time of Death
ı.	Physicia /Medic		George John Faina				April 2			11:00 P M
7	Examin		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or	Location of Death		4c. Co	ounty of Death	
. 8			Mariner Health Car	ce- Silver Spring	Silve	r Spring	8. Date of Birth		ntgomer	y lace (State or Foreign
100	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M 2	7. Age (In yrs. last birthda)	Months Days	Hours Min.	June 1,	r, Year)	Coun	try) siana
			578-01-1871 Usual Residence of Decedent				June 1,	1707	Loui	Stalla
	nyland how		10a. State 10b. County	10c. City, Town or I	Location				1	Od. Inside City Limits
	Be-f s	Directo	Maryland Prince Georg	ge's Hyatts						1 ☐ Yes 2 ☑ No
	or 2 s or 2 be no	Dire	10e. Street and Number	<b># - 0.0</b>	10f. Zip Code			10g. Citizer	n of What Coun	itry /
	eath ns 23	Funeral	2722 Kirkwood Place		. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe	acify Yes or No-	14.	USA . Race - Americ	an Indian,
36	be filed within 72 hours after death with the Maryland tal Hygiene. id other then "neturel", or Items 23s or 28e-f show event, the Madical Examination colline at	by Fun	1 Never Married 2 Married 1 I	med Forces? ⊒Yes 2 ⊠ No Yes, Give par or Dates:	If Yes, specify Cubain 1 ☐ Yes 2 No	n, Mexican, Puerto  Specify:	Rican, etc.)		Black, White, opecify: White	
Maryland 21215-0036	2 hou	ted	15. Decedent's Education	16a. Dec	edent's Usual Occupa	ation		16b. Kind	of Business/Ind	dustry
215	hin 7.	Completed	(Specify only highest grade complete state of the complete state o	pleted) (Giv life:	re kind of work done d DO NOT use retired,	during most of work!  )	ng			
2	ad wit	Con	10		ssman				nting P	ress
		e	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Su	mame)	
<u>\S</u>	2 should be filed within n and Mental Hygiene. r is marked other then 'r is market ovent, Ite Maraumetic event,  To	Peter L. Faina  19a. Informant's Name/Relationship (Type, Pr	rint) 19h Ma	iling Address (Street a	Sarah Fo		r City or T	own State Zin	Code)	
<u>N</u>	d 2 st th and th and traur		Toni Rizzo Miskell/ N		O Paddy Co				100.00	0000)
<u>6</u>	Heal Heal tem 2		20a. Method of Disposition	20b. Place of Dis	position (Name of		Date		tion - City or To	wn, State
ē	ages ent of ent of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 1 ☐ Donation 5 ☐ Other (Specify)		ematory or other place Heaven etery	April 200	. 28 <b>,</b>	Silve	er Sprin	ng. MD
altimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or other traumetic evonce.	1	21. Signature of Funeral Service Licensee		22. Name and Addres Francis J.					11.)
m	in De	0 10	Inchew &	ole	500 Univer	sity Blvd	l. W., S	Silver	Spring	g, MD 20901
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	is that caused the death. Do not e ise on each line.	nter the mode of dying	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	yocardial Infar	tion					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):						
b		-	Sequentially list conditions,	Due to (or as a consequence of):						
	uted J unsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of might) that initiated events c						- 1	
o,	exection and and rial-tra	Exa		Due to (or as a consequence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d							
9	artifica ing ph e as ti	Med	IF FEMALE:	and the second second						
Вох	leath certific attending pl	Physician/Me	23b. Was decedent pregnant		B Ectopic pregnancy			230	<li>d. Date of delive Month</li>	ory Day Year
P.0.	that the de led by the a detached i	ysic		Unknown	C Other (specify)					
٦.	that i	by Ph	Part II. Other significant conditions contribut	ing to death but not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use	contribute to th	ne cause of death?
rds	quires in signi uld be	q pa	Dysphagia, Atrial F	ibrillation			1 🗆 Y	'es 2□!	No 3 ☐ Prob	ably 4 ⊠Unknown
Records,	aw requir is been si 2 should	Completed					24a. Was			psy findings available mpletion of cause of
ž	The lay ate has page 2	Com					perfor	rmed? 2 🔯 No	death? 1 ☐ Yes	·
Vita	Physicien: The this certificate ha	Be (	25. Was case referred to medical examiner?		Lau	26. Place of Death	(Check only o	ne)		
	Physi this c al dire	은	1 ☐ Yes 2 ☒ No Hospita	1 Inpatient 2 EH/Outpati		4 KM Nursing no	me 5 Resid			y)
UC C	ding F h. After funer	tlon	1 Matural 5 ☐ Pending	a. Date of Injury 28b. Time (Month, Day Year) Injury	/ Worl	yat k? Yes 2□No	200. Describe ii	iow injury c	Couried	
Division of	l or Attencatter death Director:	ficat	3 Suicide 6 Could not be	e. Place of Injury - At home, farm,			28f. Location (S	Street and N	Vumber or Rura	I Route Number,
<u>S</u>	el or / s after I Dire d in b	Certification:	4  Homicide	building, etc. (Specify)			City or Tow	vn, State)		2
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific: completely filled in by the funeral director.	Medical C	(Check only 2 Medical Examiner: C	:: To the best of my knowledge, de On the basis of examination and/or nd manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0 = =	29c. License	e number		29d. Date s	signed (Month,	Day, Year)
	6		1/1497	12-516	D45	471		Apr	11 26,	2004
			30. Name and address of person who oumplet					100-1		
	- 2		Yeheyis Negussie/ M 31. Date filed (Month, Day, Year)	.D. 1111 Sprin	/		lver Sp	ring,	MD 209	10
**	Sta Regist		APR 2 7 2004	Serve B	Sporks	1				

	•		State						giene 200	
			Registrar		Ce	rtificate of L	Death	F	Reg. No.	9 13230
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day Yea	3. Time of Death
	/Medic	al	Katherine M. Funk  4a. Facility Name (If not institution, give street and the street)	aumhor)		4b. City, Town, or	Logation of Dogs	105	4c. County of De	1 2239 M
	Examin	er	00 1 11 001 1	Jospita	1	Cump		1	2	BANY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year	If Under 24 Hrs	9 Date of Birt	h ns	Litheless (Ctate or Foreign
	Director		214-30-9740 1DM 2\(\frac{1}{2}\)F	88	Yrs.	Months Days	Hours Min.	oct. 2	4,1915 M	laryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Lo	ocation				10d. Inside City Limits
	f sho	ō	MD Allegany		sapto					1 □ Yes 2√2 No
	h the Marylan r 28e-f show motified at	Director	10e. Street and Number	CIE	sapti	10f. Zip Code			10g. Citizen of What	Country?
	s within 72 hours after death with the Maryland Jiene. r than "natural", or items 23e or 28e-f show It e Madical Examinar roust be mailified at	al D	14916 Grant St.			21502			USA	
	ems ems	Funeral	Armed	ecedent Ever in U.S Forces?	13.	Was Decedent of Hi	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
36	or h	by Fu	1 Never Married 2 Married 1 Yes, 3 Widowed 4 Divorced Year or	s 2 ⊒No Give X		1 ☐ Yes 2 🔀 No			Specify: W	
Ş	2 hour	ed b	15. Decedent's Education	r Dates:	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busine	
215	hln 72 an "na	plet	(Specify only highest grade complete Elementary/Secondary (0-12) College	d) e (1-4or 5+)	life.	kind of work done o DO NOT use retired,	luring most of wo )	rking		ŕ
7	70 70 =	Completed	8		Нοι	ısewife			Home	
and		Be	17. Father's Name (First, Middle, Last)  Anthony L. Logsdon					me <i>(First, Middle,</i> la Kuhl	Maiden Sumame)	
Maryland 21215-0036	2 should by and Menta la marked aumatic e	은	19a. Informant's Name/Relationship (Type, Print)		19h Mailir	na Address (Street a			or, City or Town, State	Zin Code)
Ma	permit. Pages 1 and 2 should be Department of Health and Monta Important: If item 27 Is marked any injury or other traumatic as <u>once</u> .		Eugene R. Funk - S	on		6 Grant				21502
re,	item item other		20a. Method of Disposition	20b. Pla	ace of Dispo	osition (Name of matory or other place	g)	Date	20c. Location - City	or Town, State
E G	Page nent o ant: If ary or		1  Burial 2  Cremation 3  Removal fro  4  Donation 5  Other (Specify)	iii State		er & Pau		5,2004	Cumberl	and MD
Baltimore,	epartr epartr poorts ny inju	1	Signature of Funeral Service Licensee	0	22	2. Name and Addres	s of Facility H	afer Fu	neral Se	rvice PA
_	205 29		Courses & Ha	ten.						MD 21502
			23a. Part1. Enter the disease or complications the shock, or heart failure. Lest only one cause of Immediate Cause (Final	Track Communication		W. C. C. C. C. C. C. C. C. C. C. C. C. C.	g, such as carola	c or respiratory an	rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition	ARDIAC to (or as a conseque		hymna				2 HOURS
	Examiner			mus Lete	1	7 & Stock	,			
		Je.	Sequentially list conditions,  any, leaving to immediate  course. Enter linderlying	новительной в им че) от	enne cf)	T port	re-			1
_	cuted nd ransit	Examiner	Sequentially list conditions, Tany, teach is to in neutral cause. Enter Underlying Cause (Disease or Injury hat initiated events C.	RONAR.	AF	2 TERY J	1SEAS	<u> </u>		
,092	ate be executed nysician and he burial-transit		resulting in death) Last Due	to (or as a consequé	ence of):	,				
687	icate t	dical	d							
Box (	eath certificat attending phy I for use as th	/Me		outcome of pregnan					23d. Date of	delivery
	death e atte	Iciai	in the past 12 months?	e birth 2 Fetal or egnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	at the de by the a stached f	Physician/Med	9 □Unknown 9□Un							
	res that igned to be det	by	Part II. Other significant conditions contributing to	death but not resul	ting in the u	nderlying cause give	en in Part I.		_	to the cause of death?  Probably 4 □Unknown
Records,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Completed	ETATUS ENTONIA		20110	nal Wall	L Myd Right	0		
Rec	: The law cate has I	ldm	STATUS INTERIO	· vamac	TOAL	1 +46	er	24a. Was a autop perfor	sy prior t	autopsy findings available to completion of cause of ?
Vital		e Co	25. Was case referred to medical	lux	Jan	mbsis	26 Place of Do	1 ☐ Yes ath (Check only or		es 2 No
>	yalclan: is certific director,	0	examiner? / Hospital:	Inpatient 2□E	R/Outpatier	nt 3 DOA Othe	\C		ence 6 Other (S	pecify)
οl	ding Ph h. After thi funeral	T:u	27. Manner of Death 1 ☑Natural 5 ☐ Pending (M	T	28b. Time o		at		ow injury occurred	,,
Sior	Attandir death. ctor: Af y the fu	atic	2 Accident investigation		,,		Yes 2 □ No			
Division	or Attand after death Diractor:	Certification:	determined 286. Pis	ice of Injury - At hon ilding, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	spital or At ours after of heral Diraci filled in by		29a. Certifier 1 Certifying Physician: To	the hest of my know	riedne deat	h occurred at the tim	e date and place	a and due to the o	cause(s) and manner	as stated
	To the Hospital or Attanding Phyaician: within 24 hours after death.  To tha Funeral Diractor: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examiner: On the	basis of examination	on and/or in	vestigation, in my op	pinion, death occi	urred at the time, o	date and place, and d	ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo	onth, Day, Year)
)	1		> S. Chan	gru D.		J 25	6 38		may 2	2004
			30. Name and address of person who completed ca	ause of death (Item	23a) (Type,	Print)	,	- 1/	10.0	121:-23
	Sta	to	SATURNINA CHANG MD  31. Date filed (Month, MAYPAT) 2 2004	. Recorrar's Signatu	ILB CO	Heering one	reus. Wo	-/rost realing	Mayer	w 415 22
	Registi		MAY 1 2 2004	1070/ Registrar's Signatu	K,	Sports	شَد			

			For	State of Ma		Depa	artmen	t of H	lealth a		-		2001	15001
			= State Registrar			Cei	rtificate	e or L	Jeath			leg. No.	2001	15231
	Dhusiai	10	Decedent's Name (First, Middle, Las.	1)							2. Date of Dea Month	Day	Year	3. Time of Death
The state of the s	Physici /Medic		Betty Bailey Feen								April 2			1:23pm M
	Examin	er	4a. Facility Name (If not institution, give		_				Location (	of Death			county of Death	
1.36		W.	Shady Grove Advention 5. Social Security Number 6.		tal e (In yrs. last :	hirthday)	If Under	kvil	LTE	24 Hrs.	8 Date of Birth		ntgome 9. Birth	
	Funeral		11	M 25€F	89	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day March 14	Year)	15 To	nplace (State or Foreign untry) DWA
	Director		579-07-5708 Usual Residence of Decedent		09						naren 1	,,		
	yland		10a. State 10b. County		10c. City, To	own or Lo	ocation							10d. Inside City Limits
	Mar Mar	io	Maryland Montgome	ry	Gait	hers	burg							1 Tes 2 No
	or 28	Director	10e. Street and Number	•			10f. Zip	Code				10g. Citize	en of What Co	untry?
	72 hours after death with the Maryland naturel; or Iteme 23a or 28a-f show Jigal Evantraer must be redilled at		230 Beckwith Stree				208						ted St	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanıc Ori ın, Mexicar	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14	<ol> <li>Race - Ame Black, White</li> </ol>	
36	or It	by Ft	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N	ło		1 🗌 Yes	2 🕱 No	Specify:			5	Specify: Wh	nite
Ö	hour		15. Decedent's Ed	Year or Dates:	1/	6a Dece	dent's Usua	al Occup	ation			16b. Kind	d of Business/	Industry
45	n 72 n *na n *na	Completed	(Specify only highest gra-	de completed)		(Give	kind of wo DO NOT u	rk done d se retired	during mos	t of work	ring			,
12	within lene. then	E O	Elementary/Secondary (0-12)	College (1-4or 5	(+)	Воо	kkeer	er			Ī	Lumbe	r Comp	any
b	t Hygir other	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	er's Nam	e (First, Middle,	Maiden S	Витате)	
au	should be nd Mental marked c	To B	Earl Russell Baile	ev					Aga	tha	Hagerty			
Maryland 21215-0036			19a. Informant's Name/Relationship (7		1	9b. Maili	ng Address	(Street	and Numbe	er or Rui	al Route Numbe	r, City or	Town, State, Z	Zip Code)
Σ			John Feeney	(Son)					Stree		aithersl			
Baltimore,	permit Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □	Removal from State	ceme	atery, crei	osition (Nar matory or o	other plac	- 1		Date		ation - City or	
<u>E</u>	nit Pag parment ortant: I injury p		* 4 □ Donation 5 □ Other (Specify	1)	Gate	of I	Heave	n Ce	meter	у	/26/04	Sil	ver Spr	ing, MD
a	permit Depart Import any in		21. Signature of Faneral Service Licen	1/1		$ 1^2 $	Name ar Eas	t Addre	ss of Facili er Pa	irk I	Vol Fun Drive	eral	ноте	
쁘	2023		/ obert X	Wil		G	aithe	rsbu	rg, M	$\mathbb{D}^{20}$	)877			Approximate
			23a. Part1. Enter he dispase, or comp shock or heart failure. List only	olications that caused one cause on each li	I the death. D	o not en	ter the mod	de of dyin	ig, such as	cardiac	or respiratory ar	rest,		Interval Between Onseirand Death
	Physician		Immediate Cause (Final disease or condition	a. Ca	ron	m	2	In.	fer	y,	Vise	150		Years
1	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):	0	L	2.16	1:1				Marin
		-	Sequentially list conditions,	b. Qua to (or as	a consequent	on offi	3 1		00)	( )				retn
	ted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):								
760,	te be executed ysician and e burial-transit	calE	(	d										
89	The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the to	edlo									1,000		in the second	=
Вох	n cert andin use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		ath 3.f	⊒Ectopic p	regnancy	,			23	3d. Date of del	
-	deat	SICIA	in the past 12 months? 1 ☐ Yes 2 🛣 No	4☐Pregnant at			Other (sp						Month	Day Year
P.O.	at the de by the a	hys	9 🗆 Unknown			2	1007				an- Dida			the saves of death?
	res that igned I be det	by	Part II. Other significant conditions of	ontributing to death b	ut not resultin	ig in the u	inderlying o	cause giv	en in Part	l.		obaccous ′es 2□		o the cause of death?
ord	w require been si should I	ted									7	-		
Ö	elawr hasbo	Completed									24a. Was autop		24b. Were au prior to death?	itopsy findings available completion of cause of
H	10	Con										2 No	1 ☐ Yes	2 No
of Vital Records,	Physician: The ribis certificate rail director, pag	Be	25. Was case referred to medical examiner?	Hospital:	,			Oth			th (Check only o	1		
of	physic this at dir	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie	A	Outpatie b. Time o	-	OA Injur	4 🗆 141	ursing H	ome 5 Resid			cify)
	ding f	lon	1 Natural 5 Pending	(Month, Da	y Year)	Injury	м	Wor	k? Yes 2□	No	200.0000.00			
Si	or Attending after death. Director: After in by the fune	ical	3 ☐ Suicide 6 ☐ Could not b	e Jac Place of In	urv - At home	e, farm, st							Number or Ru	ural Route Number,
Division	lor A after Direct lin by	Certification:	4 Homicide determined		c. (Specify)			,,			City or Tow	vn, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying Ph	ysician: To the best	of my knowle	dge, dea	th occurred	at the tir	me, date a	nd place	and due to the	cause(s) a	and manner as	stated.
	e Ho	edical	(Check only 2 Medical Exar	niner: On the basis of and manner st		and/or in	nvestigation	n, in my o	pinion, dea	ath occu	rred at the time,	date and p	place, and due	to the cause(s)
	To th Within To th	×	29b. Signature and title of certifier	07/	7	0	29	c. Licens	e number	1	,	29d. Date	signed (Mont	h, Day, Year)
	5		Millin	Soul	1.00			1)	35	26	/	110	nil 2	-1,2004
	<u> </u>		30. Name and address of person who	completed cause of	eath (Item 23	За) (Туре	, Print)							
_			William Dooley,				nter I	Drive	e, Ro	ckvi	11e, MD	2085	0	
		ate	31. Date filed (Month, Day, Year)  ADR 2.7 26		rar's Signature	B	So	and	2/					
	Regist	ueu	1 V P P 7 / /	IS THE LAND OF THE PARTY OF THE		1 100	1.6							

			1 - For State Registrar	State of I	Marylar		artment o			_	giene,	2 A A L	15232
	Physici /Medio		Decedent's Name (First, Midd     Maria	Flores						2. Date of De Month Apri		, 2004	3. Time of Death 10:20a M
	Examir		4a. Facility Name (If not institution  Casey House	-	er)		4b. City, Tow	n, or Location			4c. (	County of Death	
	Funeral Director		5. Social Security Number 228-57-2554		Age (In yrs. 75	last birthday) Yrs.	If Under 1 Ye Months Da	ear If Uno		8. Date of Bir (Month, Da 2 / 0 2 /	th ly, Year)	9. Birthp Cour	place (State or Foreign ontry) Salvador
	Maryland -f show fied at	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Monto	jomery		ty, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 28s	Funeral Director	10e. Street and Number 16101 Crabbs	Branch W	lay	-	10f. Zip Cod	0855				sen of What Cour	•
9036	s within 72 hours after death with the Maryland Jione. r than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at	þ	11. Marital Status  1 XNever Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	s? ⊠ No		Was Decedent f Yes, specify 0 1 XYes 2 □ 1		ify:	city Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	d within giene. r than "	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4d	or 5+)	(Give	dent's Usual Ockind of work do DO NOT use re	ne during m tired)	ost of workin	g		n Home	dustry
yland	2 should be filed and Mental Hygis Is marked other surnatic event, II	To Be (	17. Father's Name (First, Middle, Justo Flores	5				Ar	ndrea	(First, Middle, Flore	es Ro	oque	
di.	and lealth m 27 her tr		19a. Informant's Name/Relations David Flores/ 20a. Method of Disposition		20b. F	494	_	tle F	alls		igtoi	Town, State, Zip n, Viro	ginia22207
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)		ate of	Heav	en 4	/29/(				ing,MD
a I			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cause only one cause on each	sed the deat							Spring	P.A. J. MD 20910 Approximate Interval Between
8760,	death certificate be executed to a steerding physician and e attending physician and idor use as the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Malig Due to (or	as a consec	neopl	asm of	f lun	ıg				Onset and Death
P.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta t at time of d	Ideath 3	Ectopic pregna				23	3d. Date of delive Month	ery Day Year
-	w requires that the de been signed by the a should be detached to	þ	Part II. Other significant conditi	ons contributing to death	n but not res	ulting in the ur	nderlying cause	given in Pa	rt I.				ne cause of death?
Vital Records	The law ate has b page 2 s	Completed								24a. Was autop perio 1 Yes	rmed?	prior to cor death?	psy findings available inpletion of cause of 2 No
of	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?     1 ☐ Yes	Hospital: 1 Inpa		ER/Outpatien 28b. Time of Injury	28c. lr	Othor	Nursing Hom	(Check only only only only only only only only	dence 6		hospice
Division	tal or Attencrs after death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Place of	Injury - At he etc. (Specif	ome, farm, stre	et, factory, office	се	2	8f. Location (5 City or Tox		Number or Rura	l Route Number,
	To the Hoapital or Attending within 24 hours after death.  To the Funeral Director: After pempletely filled in by the funer	Medical	(Check only 2 Medical one)	ng Physician: To the be Examiner: On the basis and manner	s of examina	wiedge, death tion and/or inv	estigation, in m	y opinion, d	leath occurre	d at the time,	date and p	place, and due to	the cause(s)
)	S with S	-	29b. Signature and title of certifie		m		D:	9059 numbe				il 27,2	
			Joseph Kaplan	MD 600	1 Mur	caste	r Mill	Roc	kvill	e, Md	2085	55	
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 28	1 0	strar's Signa	lture &	Span	h					

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of	of Death		Reg. No. 200	4 15233
	Physician	1. Decedent's Name (First, Middle, Las	st)			2. Dete of De Month	eath Day Ye	3. Time of Death
-	/Medical	AnneLee Broaddus	Forrester				22, 2004	11:40 am
	Examiner	4e Fecility Neme (If not institution, give	·		4b. City, Town, or	Location of Deat	h 4c. County of D	
		Maplewood Park P:	lace		Bethesda		Montgo	mery
	Funeral Director	5. Social Security Number 6. Security Number 497–28–2812  Usuel Residence of Decedent	ex	rs. last birthday) If Under 1 Ye Months Da		8. Date of Bir (Month, Date 6/17/1		Birthplace (State or Foreign Country) klahoma
	P & w	10a. Stete 10b. County	10c. C	City, Town or Location				10d. Inside City Limits
	Wery Can	MD Montgome	Dot	haada				1 □ Yes 2√∑ No
	the state of	MD Montgome	ery bet	hesda 10f. Zip Cod	io .	1	10g. Citizen of What	
	Market Services	9707 Old Georgeton	an Road	2081			USA	Country
	Jeet 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	11. Maritel Status	12. Was Decedent Ever in			pecify Yes or No		merican Indian,
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Meryland of Heelih and Mentel Hygiene.  The marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examiner mast be notified at the TO Be Completed by Funeral Director	1 Never Married 2 Married 3 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:	If Yes, specify C	of Hispenic Origin? (S Cuben, Mexican, Puert No Specify:	o Rican, etc.)	Black, W	/hite, etc.
2	led within 72 ho tyglene. her than "naturn nt, the Medical. Completed	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Usual Oc	cupetion ne during most of wor	kina	16b. Kind of Busine	ss/Industry
2	D P	Elementary/Secondery (0-12)	College (1-4or 5+)	life. DO NOT use re	tired)	\u00e4ng		
7	Co track		4	Investor			Capital Ma	arkets
2	Se se se se se se se se se se se se se se	17. Fether's Name (First, Middle, Last)					Maiden Surname)	
<u>S</u>	should to marked umartic	Jesse Norris Broad	ldus		Era Bri	.dgeford		
, Mar	end 2 sho seith end 27 le m er treum	19a. Informant's Name/Relationship (T. Anne F. Crawford -		19b. Mailing Address (Str. 14 Sutton P	eet and Number or Ru lace S Ne	w York,	NY 10022	e, Zip Code)
Baitimore, Maryland		20a. Method of Disposition 1   By Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Removal from State	Place of Disposition (Name of cemetery, crematory or other porrest Hill Cen	olace)	Date /17/04	20c. Location - City Kansas Cit	or Town, State
E D	permit. Pegs Department of Important: If any Injury or puce.	21. Signature of Funeral Service Licens	See Valo		dress of Fecility Jos			
		23a. Part1. Enter the disease, or comp	lications that caused the dea	5130 Wisc	onsin Ave.	NW Was	hington, I	OC 20016 Approximate
1	Physician	shock, or heart failure. List only o	one cause on eech line.			a	1000	Interval Between Onset and Death
1	/Medical	Immediate Cause (Final	0115.		_			1
	Examiner	disease or condition resulting in death)	e. 10E0	(or as a consequence of):				IWK
	<u> </u>							4 HONTH
	artificate be executed ing physicien and es the burial-trensit	Sequentially list conditions	b. 5720	(or as e consequence of):				HONTH
5	exec an an rial-tr	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	500.00	or as a solisadasilos oi).				1
08/00,	te be ystcie ie bu	Ceuse (Disease or injury that initieted events	C	or as a consequence of):				+
8	ig ph es th	resulting in death) Last	220.10 (	or as a sortosquerios sij.				
~	anding use e		d					
0	death e atter ed for u	Part II. Other significant conditions cor	ntributing to death but not re-	sulting in the underlying cause	given in Part I	22h Did t	ohacco use contribu	ite to the cause of death?
	nat the death c d by the attenceteched for us Physiciary	<b>3</b>		outing in the disconying educe	garon in Fact.			Probably 4 Unknown
'n	es the gigned be de							Troubly 4 dilatoni
SDIOSE	been s should					24a. Was a perfor	an eutopsy 24t med?	b. Were eutopsy findings available prior to completion of cause of death?
<u>ַ</u>	The lew ete hes b page 2 s					1□ Y	es 2DNo	1 ☐ Yes 2 ☐ No
	certificate rector, pag	25. Was case referred to medical examiner?			26. Plece of Dear	h (Check only or	ne)	
•	rhis certific ral director.	1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatient 3□ DOA	Wher:		ence 6 □Other (St	pecify)
9 7	derth neral	27. Menne Death 1 Naturel 5 □ Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of lnjury 28c. In			ow injury occurred	
5	Attanding or deeth. ector: Affer by the fune iffication	2 ☐ Accident investigation	(mamm, 2-a) really		☐Yes 2☐No			
	tal or attanding Processing of the control of the c	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pleca of Injury - At h building, etc. (Speci	nome, farm, street, factory, officity)	е	28f. Location (S City or Tow	treet and Number or i n, State)	Rural Route Number,
	in 24 hou in 24 hou he Funer pletely fill edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, death occurred at the ation and/or investigation, in my	time, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner late and place, and de	as stated. ue to the cause(s)
	with with the state of the stat	29b. Signature and title of certifier		29c. Lice	nse number	2	9d. Date signed (Mo	nth, Day, Year)
	11	1 CR	e ( /2)	m I	1262	50	4/	104
	1,2	30. Neme end eddress of person who co	empleted cause of death (Iter	m 23a) (Type, Print)	- 63		113	
		AVA AK	9VFMA	V. My	8218	Wisco	2N SIN.	>104 AVE
	State	31. Dete filed (Month, Day, Year)	32. Registrer's Signa	ature		- 1 .) - 0	0//0	
	Registrar	APK 2 7 200	14 Deneral	M Appel	1. 1			i

			1 - For State Registrar	State of N	Maryland / Depa Cei	artment of rtificate of		nd Mental H	ygiene Reg. Not	2001	15234
	Physici /Medic		Decedent's Name (First, Middle, Las     ELSA	FRIEDMA	N			2. Date of D Month APRIL		2004 Year	3. Time of Death 11;40 P.M
>	Examir		4a. Facility Name (If not institution, give		r)	4b. City, Town, Potomac		Death	4c.	County of Death	у
	Funeral Director			9X 7. A □ M 2  F	Age (In yrs. last birthday) 93 Yrs.	If Under 1 Yea Months Days		Min. 8. Date of B (Month, D June	irth lay, Year)	9. Birthp Coun Mary	lace (State or Foreign Tand
	Maryland a-f ehow	ctor	Usual Residence of Decedent  10a. State  10b. County  Florida  Broward	i	10c. City, Town or Lo			<u>.</u>		1	0d. Inside City Limits  t√□ Yes 2 □ No
	h with the 23s or 28 si be no	al Director	10e. Street and Number 3161 S. Ocean Driv	ve, # 150	8	10f. Zip Code 33009			10g. Citiz	zen of What Coun	•
036	a within 72 hours after death with the Maryland Jiene. r then "natural", or Items 23g or 28g-1 ehow the Medical Evarting remast ce rodified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	? ]No	Was Decedent of f Yes, specify Cul	ban, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	d within 72 jiene. r then "nai	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12 Years	ucation de co <i>mpleted)</i> College (1-4o	(Give life. I	dent's Usual Occu kind of work done DO NOT use retin	during most o	f working		nd of Business/Ind	dustry
/land	should be filed of the standard Magic marked other imetic event, the standard the s	To Be C	17. Father's Name (First, Middle, Last) Philip Fine					s Name <i>(First, Middle</i> Bisker			
	and 2 sho raith and h 1 27 is ma er treume	ľ	19a. Informant's Name/Relationship (7) Philip G. Berman	•				or Rural Route Numb			
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 Is marked any injuny goother treumetic e gnce.		20a. Method of Disposition 1 (XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, crem Shaarei T	natory or other pla	1 L	Date 25/2004		cation - City or To Lmore, Ma	
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licen	Stattle	Ed Ed	Name and Addr	ess of Facility	eral Direc	tion,	, Inc.	
	Priysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aColon	Cancer - M	er the mode of dy	ing, such as ca	ke, Rockv rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death 10 Yrs.
	Examiner	L.		Bone Bone	s a consequence of):  - Metastasi s a consequence of):	S					2 Yrs.
8760,	cate be executed oblysician and the burial-transit	al Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of);						
O. Box 687	death certifi e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown		2 Fetal death 3	Ectopic pregnand Other (specify)	су		2:	3d. Date of deliver	ry Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions or	ontributing to death	but not resulting in the ur	iderlying cause gi	ven in Part I.		tobacco us Yes 2 🔀	_	e cause of death?
Vital Records,	The ate h page	Completed						24a. Was auto perfe 1 🗆 Yes		24b. Were autop prior to con death? 1 \( \subseteq \text{Yes} \)	osy findings available inpletion of cause of 2 No
of	Phys r this ral di	on: To Be	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death  1  Autural 5  Pending	Hospital: 1 ☐ Inpat 28a. Date of Inj (Month, D.	urv 28b. Time of	28c. Inju	her: 4 Nursi	Death (Check only  ng Home 5 Res.  28d. Describe	idence 6	Other (Specify,	Hospice Care at s Residence
Division	or Atten after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At home, farm, stre tc. (Specify)		]Yes 2□No	28f. Location ( City or To	Street and wn, State)	Number or Rural	
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai (	29a. Certifier Check only one) Certifying Physical Example 2 Medical Example 2	vsician: To the besiner: On the basis and manner s	t of my knowledge, death of examination and/or inv tated.	occurred at the ti estigation, in my	ime, date and p opinion, death o	place, and due to the occurred at the time,	cause(s) a date and p	and manner as sta place, and due to	ited. the cause(s)
•	To the To the complet	M	29b. Signature and title of certifier	2 11	0	29c. Licen:	se number 59244		29d. Date	signed (Month, E	Day, Year)
			30. Name and address of person wood Giselle Mery, M.			Print)			20817		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 200	32. Regist	rar's Signature	Spork.					

			Please	Type or Prin								
			1 - For State Registrar	State of Ma	iryland /	Depa <i>Cer</i>	rtment o tificate d	r Health and of Death	i Mental H	ygiene Reg. No.	,	1523
	Physici /Medi		1. Decedent's Name (First, Middle, La Linda Helen Frie:	•					2. Date of I Month April	Day	2004 Year	3. Time of Death 8:02A. M
1	Examir		4a. Fecility Name (If not institution, given 4711 Lincoln Ave.	e street and number) NUC			Belts					George's
	Funeral Director		0.5 00 1001	Sex 7. Age	(In yrs. last bi	rthday) Yrs.	If Under 1 Ye Months Da			3irth Day, Year) 2,194	9. Birth Con Was	place (State or Foreign intry) hington, D. (
	Aaryland f ahow	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	George's	10c. City, Tov							10d. Inside City Limits 1 ☐ Yes 2 StNo
	with the A ta or 28a-	Direct	10e. Street and Number 4711 Lincoln Ave:				10f. Zip Cod	20705		_	izen of What Co Lted Sta	· ·
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f ahow any injury or other treumatic event, it a Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 No. If Yes, Give Year or Dates:			Vas Decedent Yes, specify C	of Hispanic Origin? Cuban, Mexican, Puo No <i>Specify:</i>	(Specify Yes or ferto Rican, etc.)		14. Race - Amer Black, White	ican Indian,
21215-0036	nin 72 hour n "netural	pleted t	15. Decedent's E (Specify only highest gra	ducation		Deced (Give I life. D	ent's Usual Oc and of work do OO NOT use re	cupation ne during most of w tired)	vorking	16b. Ki	ind of Business/I	
nd 21	be filed with all Hygiene of other than the	Be Com	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last,		·/ E	xecu	tive H		lame (First, Midd	le, Maiden	iday In	n
Maryland	should band Ments and Ments marked umatic	Tol	Irving Lee Cum	oerland Type, Print)	191	b. Mailin	Address (Str	Juanit eet and Number or	a Schla		or Town, State, Z	p Code)
re, M	s 1 and 2 f Health a item 27 is		Arthur A. Friend 20a. Method of Disposition				Lincoli lition (Name of atory or other	n Avenue	Beltsvil Date		laryland	
Baltimore,	nit. Page artment o ortant: If injury or injury or		1 XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special 21. Signature of Funeral Benyice Light	y)	Fort I	inco	oln Cem	etery 5/3				Maryland
Be	Physician /Medical Examiner		23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	one cause on each line  Non S  Due to (or as a	e. small ce consequence	44   not ente   = 11   of):	r the mode of	tying, such as cardi	Road Bel	tsvil	le, Mar	vland 2070. Approximate Interval Between Onset and Death 15 months
68760,	eath certificate be executed attending physicien and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a								
O. Box	0 0	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√□ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 Fetal death		Ectopic pregna Other (specify				23d. Date of deliv Month	rer <b>y</b> Day Year
۵.	w requires that the been signed by the should be detached	ted by Pl	Part II. Other significent conditions of Anemia	ontributing to death bu	t not resulting	in the un	dertying cause	given in Part I.		tobacco u		the cause of death?
I Records,	The law ate has b	Completed by							24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. Were aut prior to co death?	opsy findings available ompletion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other	eath (Check only			
of	ing Phys	on: To	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		utpatient Time of Injury	28c. I	4 ☐ Nursing njury at Vork?	Home 5 Re 28d. Describe			(fy)
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined		ry - At home, fa . (Specify)	arm, stre		☐ Yes 2 ☐ No	28f. Location City or T	(Street and	d Number or Rui )	al Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled in	Medical Co	29a. Certifier (Check only one)  1X Certifying Ph	nysicien: To the best of piner: On the basis of and manner stat	examination ar	e, death	occurred at the	e time, date and pla by opinion, death oc	ce, and due to th curred at the time	e cause(s) e, date and	and manner as	stated. o the cause(s)
	To the within To the	Me	29b. Signature and title of gertifie	/			29c. Lic	nse number D08754			e signed (Month,	

State Registrar

31. Date filed (Month, Day, Year)
APR 3 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas A. Bensinger, M.D. 7525 Greenway Center Dr., #205 Greenbelt, Maryland 20770 32. Registrar's Signature 2004

RENEE FUENTES Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK 04-146 04-02790 State of Maryland / Department of Health and Mental Hygiene RPD Certificate of Death Reg. No. 2 () [] [ Decedent's Name (First, Middle, Last) 2. Date of Death April 23, Day **Physician** Year Rene Mauricio 2004 556 P Fuentes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 651 Saybrooke Oaks Blvd. Gaithersburg Rear Montgomery If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 101M 2□ F Months Days Hours Min. Director 212-98-4397 44 26, 1959 El Salvador Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. works ! 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Etunit net must be a willied at Director 1 Tes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7804 Guildberry Court, Apt. Funeral 20879 E1Salvador 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married ☐ Yes 2 X No Yes, Give 0 Baltimore, Maryland 21215-0036 1₺Yes 2□No Specify: Salvadoran Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the ODGS. 12 Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gregorio Fuentes Maria Catalina Navas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11609 ueen Nicole Terrace, Germantown, MD 20876

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Jorge A. Rivas/ Brother 20a. Method of Disposition 20c. Location - City or Town, State Gate of Heaven 1 Burial 2 ☐ Cremation 3 ☐ Removal from State April 29, 1 4 ☐ Donation 5 ☐ Other (Specify) Cemeterv Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring MD 20901 23a. Part1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. TWO STABWOUNDS, MULTIPLE CUTTING WOUNDS, AND BUNT FOREE, WILL Due to (or as a consequence 4): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Dub to (or as a consequence or). Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. page 2 should be Completed 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an autopsy performed? certificate Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1XXYes 2 No Certification: To At Scene 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred SUBJECT WAS 28b. Time of Injury FOUND 28c. Injury at Work? 1 Natural 5 Pending 540 PM STABSED, CUT AND ASSAULTED thours after death. death. investigation 2 Accident FOUNDY 123/04 the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 651 5AyB?CookE filled in by 4 Homicide FOUND , GAITMERSBURG, MD To the Hospitel within 24 hours a To the Funeral I 1m WOODS

State Registrar 29a. Certifier (Check only one)

31. Date filed (8

29b. Signature and title of certifier

MARY G.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

RIPPLE

Day, Year

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

Darks

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

April 24, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 2. Date of Death Month Decedent's Name (First, Middle, Last) Day Year **Physician** APRIL 24, 2004 3:00 BEATRICE W. FUHRMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOMEWOOD AT CRUMLAND FARM NURSING HOME FREDERICK

Age / In v/S / last birthday | If Under 1 Year | If Under 24 Hrs. FREDERICK 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F Yrs 577-12-4619 Director 87 11/01/1916 NEW YORK Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. Count ir Itams 23a or 28a-f show internast be notified at 1 ☐ Yes 2♥ No MARYLAND | FREDERICK THURMONT Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16018 KELBAUGH ROAD 21788 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married al Hygiene.
I other than "natural", or went, the Wallest Example 5 1 ☐ Yes 2 🗓 No Specify: ð WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CIVIL SERVICE WORKER STATE DEPARTMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other traumatic event once. BENIAMIN WARSAW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16018 KELBAUGH RD., THURMONT, MARYLAND 21788 FREDERICK FUHRMAN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □Donation 5 □ Other (Specify) MT. LEBANON CEMETERY | 04/26/2004 | ADELPHI, MARYLAND 21. Signature of Funeral Service License 22 Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical as the attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LEFT NON-HEALING FEMUR FRACTURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signal 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 2 💢 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No ို this After thi 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending 1 ☐ Yes 2 XNo death. investigation 12:00 P<sup>M</sup> FELL AT RESIDENCE 2 Accident 09/17/2003 within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number of Bural Route Number, City or Town, State) MD 21788 4 Homicide determined 16018 KELBAUGH RD., THURMONT RESIDENCE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number APRIL 24, 2004 10 man 30. Name and address of person who completed cayse of death Item 23a) (Type, Print) ANDREW ZARICK, M.D. WEST ST., FREDERICK, MD 21701 SEVENTH 31. Date filed (Mont 32. Registrar's Signature State 2004 racker Registrar

			For State Registrar	State of N	Maryland / De	partment of				giene Reg. No. 9	2001.	1500
	Physici /Medio		1. Decedent's Neme (First, Middle, L.	FUR	NARY				2. Date of De Month April	24,		3. Time of Death 10:45 A
	Examir		4a. Facility Name (If not institution, gi Washington Adver	ntist Hosp	ital	Takom	a Pai			Mon	tgomery	
	Funeral Director			Sex 1□M 2□F	Age (In yrs. last birthd 80 Yrs	Months   D		Under 24 Hrs. lours Min.	8. Date of Bir Month, Da July 2	th 3y, Year) 4, 19:	9. Birth Copi Wash	olece (State or Foreign ntry) lington, Do
	he Maryland 28a-f show	ector	10a. State 10b. County  Maryland Montgome  10e. Street and Number	ery	10c. City, Town of		odo.			10g Citizo	n of What Cou	10d. Inside City Limits  1 Yes 2 □ No
	3a or 3	i Dir	517 Blick Dr.				904			rog. Citize	USA	iuy r
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumatic event, it a Modical Examinant is indifficut at ance.	by Funeral Director	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Deceder Armed Force 1	No No	3. Was Deceden If Yes, specify 1 ☐ Yes 2X		nic Origin? (Sp lexican, Puerto pecify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White,	
Maryland 21215-0036	within 72 housene. Than "neture"	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12) 12th		r 5+)	cedent's Usual C ive kind of work of b. DO NOT use i	one durin	n ng most of work	ing	16b. Kind	of Business/In	
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	and 2 shoulth and M	-	19a. Informant's Name/Relationship Benjamin G. Furna			ailing Address (S Blick D						Code)
Baltimore,	Pages 1 ar		20a. Method of Disposition  1 XBurial 2 Cremation 3 3 4 Donation 5 Other (Spec		20b. Place of Di cometery, of Gate of	Heaven	r place) Cem.	04/2	Date 7/2004	Silve		ıg, MD
Balti	permit. Departn Imports any inju	6 1	21. Signature of Funeral Service Lice	Onsee College		22. Name and A 11800 Ne						Home , MD 2090
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ō	Attending Physician: r death. sctor: After this certifica by the funeral director.	tion: To	1 Yes 2 Aoo  27. Manner of Death 1 Natural 5 Pending 2 Accident investigate			tient 3□ DOA e of 28c. y	Injury at Work?	1 □ Nursing Ho	me 5 Resi 28d. Describe			ν)
Division	afor Atten after deat Director:	Certification:	2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of I	Injury - At home, farm, etc. (Specify)	street, factory, or			28f. Location ( City or To		lumber or Rura	il Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier Certifying F	hysician: To the bearing and manner	st of my knowledge, do of examination and/o stated.	eath occurred at t r investigation, in	he time, d my opinio	late and place, in, death occur	and due to the red at the time,	cause(s) an date and pla	id manner as si ace, and due to	tated. the cause(s)
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	( "	- 11	30. Name and address of person who				∦a∩	5 0:1	r Cnoin	MD	20001	
	Sta	ite	Pamela Mulshi 31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	B		) STIVE	r shiii	ig, III	20901	
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	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, To	wn, or Location of			County of Deeth	1.30111
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b	Funeral		5. Social Security Number 6. Se	ex 7. Age (	(In yrs. last birthda	(V) If Under 1			f Birth , Day, Year)		ece (State or Foreign try)
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	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic avent, its Medical Exertinal must be notified at	- 52	JOAN A. FREY/WIFE			PO BOX 1		. MICHAEL			
ore	Pages 1 sent of He int: If iter		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐	Removal from State	20b. Place of Dis cemetery, of	sposition (Name crematory or othe	of or place)	Date	20c. Loc	cation - City or To	wn, State
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Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral 3 rvice Licen	500	CFSP	FELLOWS,	Address of Facilit HELFEN	BEIN & NE ST EASTO	WNAM F	UNERAL H	OME P.A.
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Division	death death ctor: y the	lical	2 Accident investigation 3 Suicide 6 Could not be determined		y - At home, farm,			28f. Locati		Number or Rurai	Route Number,
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	To t To t	Σ	29b. Signature and title of certifier	Co. A	~		icense number	7		signed (Month, L	**
			> Mussella	Such	1	1 14	4258	/	1 04	28/20	104
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Ty	pe, Print)	Factor	md 211	001		
	Sta	ato		2. Registrar		JOUC OV	CV- TUP		- ,		
	Renist		31. Date filed (Month, Day, Year)	A Bassa	A A	and s					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 28 **Physician** 2004 6:02 Edward Raymond Gesell /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster 9 Monroe Street If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1925 Months 1**⊠%** 2□ F Sept 78 MDDirector 220-18-2160 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: if item 27 is marked other than "natural", or iteme 23a or 28a-f ahow ury or other traumatic avant, the Medical Examinal most be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Nes 2 No Westminster Carroll Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21157 USA 9 Monroe Street Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1946 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify Specify: Completed by 3⊠Widowed 4 Divorced 1947 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Westminster Knit Co Sewing Machine Mechanic 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eva Blanche Autz ပ John Henry Gesell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Red Tulip Court Taneytown, MD 21787 John W. Gesell/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4/30/2004 Silver Run, MD St. Marys Cemetery ¹ 4 □Donation 5 □ Other (Specify) 21. Signature of Fugeral Service Lice Pritts Funeral"Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 mes **Physician** Metuster resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? signed Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 2/2 No 1 Yes 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? After 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Type, Print) 2015 Stener Hue Welmover MO, 21 31. Date filed (Month, Day, Year) APR 2 State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** LAVERNE GROFF 1:05 PM MAY 2004 /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JULY 7, 1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₽M 2□F PENNSYLVANIA 72 186-22-6770 Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County 10d Inside City Limits Show "netural", or Itams 23s or 28s-f shov 1 ☐ Yes 2 ☐No Director FINKSBURG MARYT AND CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2418 APPALOOSA WAY 21048 UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. int: if item 27 is marked other than "netural", or its 1 Never Married 2 Married
3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE ģ Year or Dates or than "neturn the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ ORDAINED MINISTER MINISTRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REINHART ROOKSTOOL GROFF REBA HARRIET RUPERT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA J. GROFF/WIFE 2418 APPALOOSA WAY, FINKSBURG, MD 21048 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If its any injury or o once. 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) WESTMINSTER, MARYLAND MEADOW BRANCH CEMETERY 5/8/2004 21. Signature of Forneral Service Licensee 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. Liller 91 WILLIS STREET, WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** REPIRATORY FAILURE REKS resulting in death) /Medical Due to (or as a consequence of) Examiner orth ULMOUSET Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed ADIATION/CHEMOTHERAP Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. HODGKIN'S DISCASE Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown δ signed to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No STENDSIS 1 Yes 3 Probably 4 Unknown been s EPILEPSY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate HTPONATREMA 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No м Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 \ Homicide within 24 hours a Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ATTENDING PHYSICIAN Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANUR PUDO ROJD WESMW STOR, MD2165) 904 WASHWATON L. MS 31. Date filed (Month, Day, Year) 32. Registrar Signature State 1 2 2004 Registrar

	For State Registrar	State of M	laryland / Dep <i>Ce</i>	ertificate of	Health and I Death		gienez 0 0 L	15242
	Decedent's Name (First, Middle,	Last)				2. Date of De	ath	3. Time of Death
Physician	GADI	G	EORGE			APRIL	Day Yea 23, 2004	3:10 A M
/Medical	4. Facility Name (If not inctitution			4b. City, Town, o	or Location of Death	1	4c. County of De	ath
	SUBURBAN HOSPITA	AL		BETHESDA			MONTGOM	
Funeral	,	6. Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)	irthplace (State or Foreign Country)
Director	194-10-9537 Usual Residence of Decedent		88 Yrs.			MAY 26,	1915 PEN	INSYLVANIA
and land	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
death with the Maryland ms 23a or 28a-f ehow rinust be notified at	MARYLAND MONTGO	MERY	ROCKVILLI				10- Cisi of W/4	1 No 2 No
with the second		" " " " " " " " " " " " " " " " " " " "		10f. Zip Code			10g. Citizen of What (	Country?
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Ster death virtems 233	1 Never Married 2 Marrie	Armed Forces	No WWII	If Yes, specify Cubi	an, Mexican, Puert	o Rican, etc.)	Black, Wi	nite, etc.
Urs al	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	KOREAN	1 ☐ Yes 2 ∏ No	Specify:		Specify: W	HITE
21215-00 ed within 72 hou ygiene. "naturu naturu it, tre Medicale	15. Decedent	s Education	16a. Dec	edent's Usual Occup re kind of work done	pation during most of wor	kina	16b. Kind of Busines	s/Industry
athin athin	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	d)	·		
tygier the riter of the riter o		acti	ELEC.	TRONICS RI		ne (First Middle	CIVIL SER' , Maiden Sumame)	ATCE
Maryland 21215-0036 and 2 should be filed within 72 hours all lith and Mental Hygiene. 27 Is marked other than "naturel", or rireumatic event, the Marical Examination of To Be Completed by E	í		EORGE		LTLLTAN			an.
should Ind Men In market	P   EDWARD 19a. Informant's Name/Relationsh			ling Address (Street			BAYT. ( er, City or Town, State	
Ma nd 2 s Lith ar 1 treu	MIMI TORREANO/DA						, MD 20850	
s 1 ac f Hea item other	20a. Method of Disposition		20b. Place of Disp			Date	20c. Location - City	or Town, State
Page Fage	1 ☐ Burial 2 [XCremation '4 ☐ Donation _5 ☐ Other (Sp		9   ·			27/2004	ALEXANDRIA	A, VIRGINIA
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylat Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow eny injury prother treumatic event, Ite Medical Examinar must be notified at once.	21. Signature of Funeral Service L	icensee	, i	22. Name and Addre	ess of Facility	MEMORT	AL CHAPELS VILLE, MD	. TNC.
	23a. Part1. Enter the disease, or shock, or heart failure. List of		ed the death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
Pnysician	Immediate Cause (Final disease or condition	/	Wille r	Mrolle	deal &	MAN:	tien	Onset and Death
/Medical	resulting in death)	a Due to (or a	s a consequence of):	0		1		
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60, be executed ician and burial-transit	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):			<u> </u>		
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687 (687 g physis as the b		0.						
Box 68 Box 16 Box 61 Bo	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pregnance			23d. Date of d	elivery
P.O. Box 68766 nat the death certificate be do by the attending physicic etached for use as the burnel circum.	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			Other (specify)	y		Month	Day Year
P.O. that the de detached		ns contributing to death	but not resulting in the	underlying cause oil	ven in Part I	23e. Did t	obacco use contribute	to the cause of death?
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ecord law requir as been si						24a. Was	an 24b. Were	autopsy findings available
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of Vital R Physician: The	25. Was case referred to medical					ath (Check only o	one)	
Of V Of V Physic ral dire	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat		ent oll box			dence 6 □Other (Sp	pecify)
ing P	27. Manurer of Jeath 1 Natural 5 Pending		ury 28b. Time ay Year) Injury	Wo		28d. Describe	how injury occurred	
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Division  Division  I or Attending after death.  I Director: After fund of the fundation of	27. Manner of Teath 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	building, e	etc. (Specify)	treet, ractory, onlos		City or To		
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,	29h Signature and title of certifier	woman	KINHOO	29c. Licens	se number	14	29d. Date signed (Mo	nth, Day, Year)
241				140	13470	10 K	4/00/0	7
	DR. M. MEANSMA				TOWN ROAD	, BETHES	SDA, MD 208	314
State	31. Date filed (Month, Day, Year)	32. Raigis	trar's Signature	Spark				
Registra	APR 2 7	2004	neva 19	RYSTORA	del			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 25,2004 12:33PM Greene April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2400 Michigan Ave Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 25, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1□ M 2□€ 216-50-9570 84 Yrs. Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County \*ohe r than "natural", or Items 23a or 28a-f eho: the Medical Examinar must be notified at 1 XYes 2 No Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2400 Michigan Ave 20910 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Black ģ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Freedman's Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurse permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygier
Important: If item 27 is marked other than any Injury or other traumatic event, IIIs
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Mary Harris Oscar ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 20904 19a. Informant's Name/Relationship (Type, Print) Deloris Gassaway-Daughter 1801 Smith Village Rd Silver Spring, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial 4/30/2004 Rockville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N Washington St Rockville, MD20850 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days 0515 /Medical Due to (o as a consequence of): Examiner SSULE Sequentially list conditions, if any, leading to immediate cause Fried Indaming Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-transit The law requires that the death certiticate be executed Exami Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy tō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached t P.0. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown as been si Be Completed 24a, Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certiticate ha 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely tilled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gute 31. Date liled (Month, Day, Year) 32. Registrar's Signature State APR 28 2004 Registrar

State of Maryland / Department of Health and	-	-	
1 - State Registrar Certificate of Death		<sub>9, No.</sub> 2004	15244
1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death
Physician PAYTON GRIFFIN		26 2004	8:45 P M
Examiner  4a. Fecility Name (If not institution, give street and number)  SHADY GROVE ADVENTIST HOSPITAL  ROCKVILLE	th	4c. County of Death	EDV
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr	s. 8. Date of Birth		place (State or Foreign ntry)
Director 578 24 0182 STAN 2 F 81 Yrs. Months Days Hours Min	March 1		th Carolina
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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Md. Montgomery Damascus  106. Street and Number  107. Zip Code	10	0g. Citizen of What Cou	ntry?
10904 Middleboro Drive 20872		United Sta	
10 304 MTddTeD0T0 DTTVe Z0072  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married	specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White,	
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Md. Montgomery  10c. City, Town or Location  Md. Montgomery  10c. City, Town or Location  Damascus  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  11e. Was Decedent Ever in U.S. Amed Forces?  11e. Yes 2 No Specify:  11e. Yes, specify Cuban, Mexican, Pue  11e. Yes, Give  Year or Dates:  WWII  16a. Decedent's Usual Occupation  (Give kind of work done during most of work done during mos	orking	16b. Kind of Business/Ir	ndustry
Elementary/Secondary (0·12) College (1·4or 5+)  11 College (1·4or 5+)  Manager		Restaurar	· <del>+</del>
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Albert Sydney Griffin O'Kee	se Cog	gin	
The state of the s			code) 20872
Stevent III. drillin / Son 10904 interested by 1		20c. Location - City or T	
1   Burial 2   Cremation 3   Removal from State   Cemetery, crematory or other place)   1   Burial 2   Cremation 3   Removal from State   Metropolitan Crem.   4/	28/04	Alexandria,	. Va.
3 Millioned 4 Divorced Specify:    1			
P. U. BOX 5038	, Laytons	ville, Ma.	20882
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carding shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition   ASPIRATION PNEUMONIA	ac or respiratory arre	est,	Approximate Interval Between Onset and Death DAYS
/Medical resulting in death)  Due to (or as a consequence of):  CEREBROVASCULAR ACCIDENT			Davic
Sequentially list conditions b.			104]
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			
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O = 1 Yes 2 No Prospital 1 Inpatient 2 ER/Outpatient 3 DOA Over 4 Nursing 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other (Speci	fy)
25. Was case referred to medical examiner?  1			
27. Manner of Death 1 Natural 2 Noticide 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Natural 2 Noticide 4 Homicide 28b. Time of Injury M 1 Noticide 28b. Time of Injury M 1 Noticide 28b. Time of Injury M 1 Noticide 28b. Time of Injury M 28b. Time of Injury at Work? 1 Noticide 28b. Time of Injury at Work? 1 Noticide 28b. Time of Injury at Work? 28b. Time of Injury at Work? 28b. Time of Injury at Work? 28c. Place of Injury - At home, farm, street, factory, office	28f. Location (St. City or Town	treet and Number or Rur n, State)	al Route Number,
Ce de division of the control of the	,		
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plate of the control			
2		29d. Date signed (Month,	Dav. Year)
one) and manner stated.  29c. License number	2		
29453	2	APRIL 27,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	KVILLE, M	APRIL 27,	

		-	_ State	State o	of Maryland		irtment of H	Health and M		iene <sub>eg. No.</sub> 20 (	) 4	15245
			Registrar  1. Decedent's Name (First, Middle, Last)				inouto or	204	2. Date of Deat	th		3. Time of Death
	Physicia	an		36	مداد دار	4400			Month April		Year 04	5:15 A. <sup>M</sup>
>	/Medic	-	Beatrice  4a. Facility Name (If not institution, give si	M.	Gudr	Tage	4h City Town	or Location of Death	April	4c. County o		J.13 A.
	Examin	er										7417
-			Wilson Health Care 5. Social Security Number 6. Sex		7. Age (In yrs. la	ast birthday)		rsburg If Under 24 Hrs.	8. Date of Birth	Mont		ace (State or Foreign
	Funeral Director			M 2⊠F	86	Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 24	Year)	Coun	York
		1	Usual Residence of Decedent		00				100. 24	, 1510	11011	TOTIC
	land		10a. State 10b. County		10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	Man Ite	to	Maryland Montgome	ry	G	aithei	sburg					1⊠Yes 2 No
	7.288	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wi	nat Coun	iry?
	death with the Maryland ms 23a or 28a-f show		514 Russell Avenue				2087	77		United	Sta	tes
	death ms 2	Funerai		2. Was Dec	pedent Ever in U.S	S. 13. \	Vas Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race	- America	
	or Ita	Ē	1 Never Married 2 Married	Armed F	2 <b>X</b> No		Tes, specify Cub I ☐ Yes 2 No		rican, etc.,	Specify:	, vviille, c	nc.
9500-61212	hours after tural', or Ita	þ	3X Widowed 4 □ Divorced	If Yes, G Year or (	Dates:		103 22 140	арвену.		эреспу.	WI	nite
r D	72 hc	etec	15. Decedent's Educ (Specify only highest grade	ation completed	,	(Give	lent's Usual Occu kind of work done	during most of work		16b. Kind of Bus	iness/Ind	ustry
Z	within 72 ene. than "nat	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	(d)		_		
	filed with Hygiene. other then	Completed			+	Jo	urnalist	18. Mother's Nam	- 45° - 44° - 44° - 4	Journa		Ω
ם	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or Itams 23a or 28a-f show event, tra Medical Examination invalidation as	Be	17. Father's Name (First, Middle, Last)					18. Mothers Nam				
<u>Xa</u>	Men Men arke	၉	Christian		lau1				Beatri		sher	
Maryland	2 sh and and is m		19a. Informant's Name/Relationship (Typ	e, Print)			•	and Number or Rui				
2	permit. Pages 1 and 2 should be fit Department of Health and Mental H, Important: If item 27 is marked out any injury or other traumatic even once.		Kevin Gudridge/Son		20h BI		Harvard sition (Name of	Avenue, #		attle, \ 20c. Location - C		
0	H ite		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Re	emoval from	State CE	emetery, crei	natory or other pla	(ce)				
Baltimore,	Pag men men mant:		* 4 □ Donation 5 □ Other (Specify)		Met	ropoli	tan Crem	atory 4/2	2/2004	Alexand:	ria,	Virginia
ğ	epart epart nport ny in nce.		21. Signature of Funeral Service License	1,6	0.01			ess of Facility De				222==
_	70 E S 9	Ta V	Michael	SNT				er Park D			g, M	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on	caused the death each line.	n. Do not ent	er the mode of dy	ng, such as cardiac	or respiratory arr	est,	i	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	RF	=SPIR	ATO	RY	HAILU	RE			
	/Medical		resulting in death)	Due to	o (or as a consequ	ence of):		1000	C0		_	
ŧ	Examiner		Sequentially list conditions, b	(0	NGES	- Land	IE /	1EART	FA	ILUKE		
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	zence of):	1	C 000	D	Crac	<u>ب</u>	
	ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	Due to	O CO N	AR Y	7 []	EAR	DI	SEHJ	_	
50,	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit			D00 ((	O as a consequ	rence or).					000	
8760	ate b hysic the b	dicai		_							-	-
9 X	eath certific attending p	Physician/Med	IF FEMALE:	a lives o	utcome of pregna	nav				004.0-1-	of delian	
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnal birth 2 Fetal	death 3	Ectopic pregnanc	°y		23d. Date Mon		ny Day Year
0	at the de by the a tached f	/sic	1 ☐ Yes 2 XNo 9 ☐ Unknown	4∐Preg 9☐Unk	gnant at time of de nown	eath 5L	Other (specify)					
<u>С</u>	that the		Part II. Other significant conditions con	tributing to	death but not resu	alting in the u	nderlying cause g	ven in Part I.	23e. Did to	bacco use contril	bute to th	e cause of death?
ŝ	res tha signed be del	by	Patti. Other significant conditions con	tributing to	33411 231 1101 1330	21.1119 111 1110 1		737777	1 □ Y	1-4		ably 4 DUnknown
Records,	w require been si should I	Completed										
ec	e law has b	nple							24a. Was a autops perfori	sy pr	ere autor for to cor eath?	osy findings available inpletion of cause of
=		S									Yes	2□ No
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ital:			0	26. Place of Dea	th Check only on	10)		
	shysi this c	٢	TO THE ZONO			ER/Outpatier	it 3 DOA		ome 5 Reside			)
Ē	ding P h. After funera	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time o Injury	Wo		28d. Describe no	ow injury occurre	a	
Division of	Attending Physician: If death. Sector: After this certific by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	One Die	an of loium. At he	ma farm at		Yes 2 □ No	28f Location /S	treet and Numbe	r or Rura	I Route Number
Σ	i it te	E	4 Homicide determined	buil	ce of Injury - At ha ding, etc. (Specif)	/)	eet, factory, office		City or Town		, Or Fibra	Troute Warnbor,
	urs a bral [		29a. Certifier (Cartifying Phys	delen Te M	no book of my know	wladaa daat	h assurand at the	mo data and place	and due to the o	auco(s) and man	200 20 0	ated
	Hos 24 ho Fun fely f	lica	29a. Certifier Cartifying Physical Cartifying Physical Cartifying Physical Examination (Check only one)	nar: On the								
	To the Hospital or Attending Physician: Within 24 horus after death. To the Funeral Diractor: After this certific Dempletely filled in by the funeral director.	Medical	29b. Signature and title of certifier	and ma	o. statod.		29c. Licen	se number	2	29d. Date signed	(Month, i	Day, Year)
)			M. Cum	Vo	MIINI	1 1.41	D3	35791		4/20	0/0	4
	12		30 Name and address of the said	moleted a-	use of death the	239) /7::00	Print) Mer	luss vemu	024, M.D	./	/	
		The state of the s	30. Name and address of person who co	mpieted ca	AVE	, 25a) (Type,	ILVER	SPRI	NE -	MD:	209	102
	Sta	ite	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	iture _	0	-//-		-		
	Regist		APR 27 200	14	Seperar	5	Spack	2				

			r rease r	State of Marylar					•	ene	
		_	For State Registrar		•	rtificate o				. No. 2004	15246
	Physicia	an	1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day Year	3. Time of Death
	/Medic	al .	Dora A. Guevara  4a. Facility Name (If not institution, give st	treet and number)		4h City Town	n, or Location of		oril 22	<b>2004</b> 4c. County of Dear	4:50am <sup>M</sup>
•	Examin	er	Casey House	reet allo number)		Rockv		Dout		Montgome	
	Funeral		5. Social Security Number 6. Sex	M OFFICE		If Under 1 Yes		Min.	Date of Birth (Month, Day, Y	'ear) 9. Bird	thplace (State or Foreign
	Director		220-15-0009 Usual Residence of Decedent	73	Yrs.			De	ec. 10,	1930 E1	Salvador
	yland		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation	_				10d. Inside City Limits
	Ba-f sl	Director	Maryland Montgomer	y Ga	ithers					0:::	1 ☐ Yes 2 🔀 No
	with the		10e. Street and Number	D !		10f. Zip Code 20886				. Citizen of What Co	,
	death with the Maryland rms 23a or 28a-f show r roust be notified at	Funeral	7838 Yankee Harbor  11. Marital Status	2 Was Decedent Ever in I	J.S. 13.	Was Decedent of If Yes, specify C		in? (Specify		14. Race - Ame Black, Whit	erican Indian,
ထ္	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give						an Specify: Wh	
Maryland 21215-0036	be filed within 72 hours after death with the Marylar death yylaine.  death yy	ed by	3X Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usual Oc	cupation	<del></del>		6b. Kind of Business	
2 2 2	hin 72 an "na Madic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work do DO NOT use ret	ne during most tired)	of working			
21	ed wit ygjene rer the	Com	7		Hon	nemaker	10 Mathe	de Nama /F	icat Middle Ma	Own home	
and		Be C	17. Father's Name (First, Middle, Last)							Guevara	
2	s 1 and 2 should be if Health and Menta item 27 is marked other traumetic o	٢	Doroteo Reyes  19a. Informant's Name/Relationship (Type	oe, Print) (Daughte	19b. Maili	ng Address (Stre	eet and Number	r or Rural R	oute Number, (	City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Anna Elizabeth Mod	enessi	7838	Yankee	Harbor	Driv	e, Gait	hersburg,	MD 20886
Baltimore,	ges 1 if iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amount from State	cemetery, cre	osition (Name of matory or other p	place)	Date		c. Location - City or	
Ħ	artmen ortant: injury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>		2	Name and Ad	dress of Facility	DeVo	1 Funer	ilver Spr al Home	ing, MD
Ba	permit. Pages 1 Department of H Important: If ite any injury or otl		Votert HL	201	111	) East D lithersu	eer rar	CK DEL	ve		
			23a. Pan1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the dea ne cause on each line.	th. Do not en	ter the mode of	dying, such as	cardiac or re	spiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Metastatic		Cell Lu	ing Cano	er			6 Months
	/Medical Examiner			Due to (or as a conse	quence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Error to serving Cause (Disease or injury	Due to (or as a conse	quence of):						
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of).					,	
760,	ate be executed nysician and he burial-transit	cai E		1	40000						
68	tificate ug phy: as the		Communication of the Communica						==		
Вох	ath cer ttendir or use	lan/N	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1☐Live birth 2☐Fet	al death 3	⊒Ectopic pregna				23d. Date of de Month	livery Day Year
0	The law requires that the death certificat to has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4⊡Pregnant at time of 9⊡ Unknown	death 5t	Other (specify	)				
<u>α</u>	signed by	by Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying cause	given in Part I.		23e. Did toba	cco use contribute to	o the cause of death?
ord S	w require been sig should b								1 🗌 Yes	2 □ No 3 □ P	robably 4XJUnknown
Vital Records,	e lawr has be je 2 sh	ompleted							24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
alF		e Cor	25. Was case referred to medical		·		OC Piece	of Dooth (C	1 ☐ Yes 2 ☐	XNo 1 ☐ Yes	s 2□ No
	Phyaician: this certific ral director,	To Be	eyaminer?	lospital:   Inpatient 2	] ER/Outpatie	nt 3□ DOA					ecity) Hospice
n of	ng Phys fter this ineral di	L:uo	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. I	njury at Work?	280		injury occurred	
Division	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I	nome farm st		1 ☐ Yes 2 ☐ I		. Location (Stre	et and Number or R	ural Route Number.
Ď	al or A s after Il Direc d in by	Certification:	4 Homicide determined	building, etc. (Spec	ify)				City or Town,	State)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (	29a. Certifier 1⊠. Certifying Phys (Check only one) 1 ☐ Medical Examin	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, dea nation and/or in	th occurred at the	e time, date and ny opinion, deat	d place, and th occurred	I due to the cau at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the l within 2 To the l	Me	29b. Signature and tille of certifier	10		29c. Lic	ense number		290	d. Date signed (Mon.	th. Day, Year)
	4		celani	//		- 06	DØ 41	218		7/22/0	74
			30. Name and address of person who co	ompleted cause of death (Ite			Rockwil	11e. M	D 2085	5	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature /	Spour			20032		
	Regist	rar	APR 27200	14	1	pagara	w hor				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

-03064														I Copie		_	ble.		
	-	For Uni	pend It	em	#23a&2	7 <sup>Ma</sup> p	er ii	ie (8	gart <i>ertii</i>	5793 ficate	704 <sup>H</sup>	ealth a Cas Death	and M	lental H	ygier Reg. N		04	1524	. 7
4		1. Decedent's Nam	e (First, Middle	e, Last)										2. Date of [	Death		-	3. Time of Dea	ath
Physicia		Dorothy	,		Jean			Go	1ds	teir	1			May 5	. 20	04	Year	1032 P	_ M
/Medica		4a. Fecility Name (I		. aive s		mber)						Location	of Death	- 2	-		of Death	1002 1	-
Examine		Anne Arui					,					olis	or D'Outin				e Aru	indel	
5		5. Social Security N		6. Sex				last birtho	(av) I		1 Year		24 Hrs.	8. Date of E	Birth			place (State or Fo	reian
Funeral Director	-	212-68-1	.777	1 🗆				49 Yrs	M	fonths	Days	Hours	Min.	Feb.	19	55	Cour	ington,D	
and *	}	Usual Residence of 10a. State	10b. County				10c. Cit	y, Town o	r Locati	ion							1	Od. Inside City Li	imits
sho	5	V1 1		- 0-			_											1 X Yes 2 □	
28a-1	Funeral Directo	Maryland  10e. Street and Nu	Prince	2 66	orges		Вот	wie	1.	10/ 7:-	Onda.				10- 6	7/a/man ad 1	M/h - A O	0	
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ath v	<u>a</u>		stview					-			20720					U.S.			
tems		11. Marital Status	v		2. Was Dec	orceş?		.S.	13. Was	s Decedes es, spec	ent of His ify Cubar	spanic Ori n, Mexicar	gin? (Spa 1, Puerto	ecify Yes or h Rican, etc.)	NO-		e - Americ ck, White,		
s afte	7	1 Never Marr		ied	1 ☐ Yes If Yes, Gi	ve	0		1 🗆	Yes 2	No	Specify:				Specif	v: Whi	ite	
urel'	9	3 Widowed			Year or D	Dates:									1				
nat die	Completed	(Spec	15. Decedent city only highes					1 (6	ive kind	d of won	Occupa k done d	lu <i>rina</i> mos	t of work	ing	16b.	b. Kind of Business/Industry			
hen hen	E	Elementary/Seco			College (	1-4or 5	+)	] "			e retired)	,					. 1		
led v lygie her t		12		1 4					0	wner	:	40 Mark			_	Hair Salon			
d otl	e n	17. Father's Name	(FIRST, MIGGIÐ,	Last)		0 - 1 -								e (First, Midd		en Suman			
Men arke	2	George				Sala	ımy					Thel			С.		Igal		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event. It a Mardical Exertic or must be recified at once.		19a. Informant's N				1			_					A Route Num					00
and salth n 27 ser tr	ľ	Daniel Go	rasteri	1/ H	lusban	a. 		1400				w For			Bor	vie,	Maryl	Land 207	20
of He		20a. Method of Disposition 1 Burial 2		2 🗆 🗈	omoval from	Stato	20b. P	Place of Di cometery,	ispositio cremato	on (Nam ory or ot	e of her place	e)		Date	20c.	Location -	City or To	wn, State	
Page nent nr: In		° 4 ☐ Donation			emovarmom	State	Hur	ntt C	rem	ator	У	5	/7/2	004	Wa]	ldorf	, Mar	yland	
mit.		21. Signature of F	neral Service	icense					22. Na	ame and	Addres	s of Facilit	y Rob	ert E.	Eva	ns F	unera	1 Home	
Depar Impo any ir		1/-	1/	15	$\triangleleft$				160	00 A	nna	polis	Roa	d, Bow	ie,	Mary	land	20715	
		23a. Part1. Enter t	he disease, or	complic	cations that	caused	the deatl	h. Do not	enter th	he mode	of dying	g, such as	cardiac o	or respiratory	arrest,			Approximate	
		shock, or hea	rt failure. List (Final	only on										. 1 (171)	1			Interval Between Onset and Deat	n th
Physician /Medical	ij	disease or condition resulting in death)	on	a				_		ry D	isse	ectio	n Wl	th Thr	ombo	SIS	_		
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sit sit	cause. Enter Underlying Cause (Disease or injury																		
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th ce tendi	a L	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death							th 3 Ectopic pregnancy						23d. Date of delivery		,		
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w requires that been signed to should be detailed.	ò									co use contribute to the cause of death?			1?						
quire an sig uld b		1 Yes 2 No								3 Prob	ably 4 Whitn	own							
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n: T ficate or, pa		25. Was case refer												1 Yes		lo '	Yes	2□ No	
ding Physicien: The Ish.  After this certificate ha funeral director, page funeral director		examiner?			ospital:	-					Othe	r		(Check only	-				
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tel or Attending P rs after death. el Director: After I ed in by the funera		4 Homicide	determ		28e. Place build	of Injuing, etc.	ry - At ho . <i>(Specif</i> )	ome, farm, v)	, street,	factory,	office			28f. Location City or T	(Street a own, Sta	ind Numb te)	er or Rura	l Route Number,	
itel c													Į.						
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	2	29a. Certifier (Check only	1 Certifyin Medical	g Phys Examin	icien: To the	best o	f my kno examina	wledge, d	eath oc	curred a	t the time	e, date an	d place, a	and due to the	e cause(	s) and ma	nner as st	ated.	
thin 24 hours thin 24 hours the Fune impletely fil	e c	one)			and man	ner stat	ed.						5000111						
To To t	3	29b. Signature and	title of certifier								License				29d. D	ate signe	(Month, l	Day, Year) A	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AND RUS 10, HD

31. Date filed (Month, Day, Year)

AY 0 7 2004

32. Registrar's Signature 7 2004

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) May 6, 2004

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of	Marylar			nt of H te of L		nd M	ental Hyg	jiene leg. No. 2 (	04	15248	
	Physicia /Medic	al		WNTE.			4. 0	-			2. Date of Dea Month	Day	Year OY	3. Time of Death 7 (27 AM	
	Examin uneral	er	4a. Facility Name (If not institution, give CARRO CHOSP)  5. Social Security Number 6. S	774 C	ENE	last birthday)	w	E ST	Location of  ///  If Under 2	STE	8. Date of Birth (Month, Day	1	RRE	colace (Stete or Foreign	
P	irector	}	220–46–4305  Usuaf Residence of Decedent  10a. State 10b. County	□M 3√√F	99 10c. Cit	Yrs. ty, Town or Lo		50,0			JULY 26	5,1904	MAI	RYLAND  10d. Inside City Limits	
th the Mary	or 28a-f ah e notified u	Irector	MARYLAND CARROL  10e. Street and Number	L	F	HAMPSTE		p Code			1	log. Citizen of	What Cou	1 Yes 2 No	
<b>5-0036</b> 72 hours after death with the Maryland	nd other than "natural", or Itama 23a or 28a-f ahow event, If a Medical Exeminar must be notified at	by Funeral Director	4016 BECKLEYSVI  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	TLE ROAD  12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	ent Ever in U es? No		Nas Dece	cify Cubai		in? (Spe Puerto l	cify Yes or No- Rican, etc.)	Blac		can Indian, etc.	
<b>21215-0036</b> 9d within 72 hours af	r than "natur It a Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		or 5+)	life.	kind of we	ork done d ise retired,	uring most o	of workir	ng	16b. Kind of B		dustry	
S bluc	marked othe	To Be C	17. Father's Name (First, Middle, Last)  JOHN WESLEY REAV			10h Maiti	a Address	- /Street	ADD	IE A	GNES HA	AIFLEY	aiden Sumame) [FLEY		
or are of Hea	item 27 Is other trau		19a. Informant's Name/Relationship (1) PEGGY MARTIN/DAU  20a. Method of Disposition  10 Burial 2 Cremation 3 Company  4 Donation 5 Other (Specify	GHTER Removal from Sta	ato   C	4016 Place of Dispo	BECK sition (Na.	LEYSV me of other place	TLLE	RD,		STEAD, I	MD 2 City or To	1074	
Balti Permit.	important: If any injury or once.		21. Signature of Funeral Service Licenter	Suit			ERS-I 1 WI	DURBC LLIS	STREE	UNER T	AL HOME WESTMIN	STER. 1	MD 2	1157	
/M	sician ledical aminer	Je.	23a. Pegt 1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate	a. Due to (or	as a consequence as a c	Quence of):	er the mod	se or aying	g, such as ca	ardiac of	respiratory arm	est,		Approximate Interval Between Onset and Death	
Box 68760, Code the certificate be executed	physician and s the burial-transit	dical Examiner	cause. Enter Underlying Causes (Usease or if they that initiated events resulting in death) Last	с.	as a conseq										
, P.O. Box 6 that the death certific	by the attending ached for use as	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow	n 2 ∏Feta t at time of d	Il death 3	Ectopic p Other (sp						te of delive	ery Day Year	
	been signed t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
<u>۾</u> ڇ	2 38	Completed	25. Was case referred to medical examiner?  1  Yes 2 No								prior to co death?	psy findings available mpletion of cause of			
	er this certil ieral directo	n: To Be										y)			
Division for Attending	To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	Certification:	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide determined (Month, Day Year) Injury Work?  2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No  28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural City or Town, State)									l Route Number,			
the Hospital	To the Funeral Diractor: completely filled in by the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the be niner: On the basi and manner	s of examina	owledge, death ation and/or inv	occurred restigation	at the time, in my op	e, date and inion, death	place, a	nd due to the ca	ause(s) and ma ate and place, a	anner as si and due to	ated. the cause(s)	
Tot	2 8	M	29b. Signature and title of certifier	Frank	tel,	0,0		c. License	number 058	359	98	9d. Date signed	Month,		
	Sta Registr	-	30. Name and address of person who of DR, TRINA KAI 31. Date filed (Month, Day, Year)	POOR F	of death (fren APV) istrar's Signa	REZ	8 4	8-0	ROLI	EK	ED WE	STMI	V 572	21157 2,ND	

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment o rtificate d		and Mental F	lygiene	1000	152	1.0	
Ħ	Dharia		1. Decedent's Name (First, Middle, Last	)				2. Date of Month		0.0	3. Time of	f Death	
	Physic /Medi		Mary Loui		man			April	24	2004	8:45	РМ	
	Exami	ner	4a. Facility Name (If not institution, give	,			m, or Location of	of Death	4c.	County of Death	1		
	E		Suburban Hospital  5. Social Security Number 6. Se		(In yrs. last birthday)	Be If Under 1 Ye	thesda	24 Hrs. 8. Date of		ontgome		or Famian	
	Funeral Director			M 2015	85 Yrs.		ys Hours	Min. (Month,	Day, Year) 7, 191		place (State of Intry) Lucky	ir r-oreign	
	pu ,		Usual Residence of Decedent						, ,	.,			
	shov	7	10a. State 10b. County		10c. City, Town or Lo						10d. Inside Ci	•	
	the M	ecto	Maryland Montgome  10e. Street and Number	ry	Silv	er Spri			10c Citi	zen of What Cou		-X	
	3a or	Ö		. U.wld Di	#210					ed Stat	•		
	deeth	Funeral Director	2900 North Leisure	12. Was Decedent E		Was Decedent	<del></del>	gin? (Specify Yes or , Puerto Rican, etc.)		14. Race - Amer	ican Indian,		
9	or its	F.	1 ☐ Never Married 2 🔀 Married	Armed Forces?  1  Yes 2 N If Yes, Give	0	irres, speciny 0 1 ☐ Yes 2 🛣 i		, Puerto Hican, etc.)		Black, White Specify: Whi			
8	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:									
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or itams 23a or 28a-1 show ont, I'm Medicul Evar ther most be notified at	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Oc kind of work do DO NOT use re	ne during most	of working	16b. Kir	nd of Business/h	ndustry		
212	d with jiene. r thar	mo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	nistrat	,	istant		Retail			
ğ	a - 0 %	BeC	17. Father's Name (First, Middle, Last)					r's Name (First, Mide	dle, Maiden	Sumame)			
<u> </u>	should be fand Mental Is marked or	To	Hoyt C. H	iggins				Lola M	. Nola	and			
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Importants: If item 27 is marked any injuryer other traumatic evone.		19a. Informant's Name/Relationship (Ty	,				r or Rural Route Nur		Mar	harly	20906	
	1 and Health am 27 thar t		Hubert Lee Hoff  20a. Method of Disposition	man/Husbar	2900 2900 20b. Place of Dispo	North L	eisure	World Blv		10, Sil-	ver Spi	ring	
Baltimore,	ages nr of rr		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, cree Arling National	natory or other.	place)	May 17,					
Ħ	nit. Partme ortan injuri		21. Signature of Funeral Service Licens	90	NationaP	Cemete: 2. Name and Ad	ry Idress of Facility	2004 Robert A.	Arli	ngton, V hrev Fu	/irgini neral H	.a Home/	
ä	Depariment of the second of th		1 DE PORSE	mc MC	)1356 R	ockville ockville	e, Inc.	Robert A. 300 West land 2085(	Montg	omery A	venue,	,	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Congest	the death. Do not enter.  ive Heart consequence of):			cardiac <i>o</i> r respiratory	/ arrest,		Approximate Interval Bett Onset and D	ween Death	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai Examiner	ause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):								
O. Box 6	it the death certific by the attending p tached for use as	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   23c. If yes, outc							3d. Date of deliv		/ear		
S, P	es tha igned be det	by P	_		ulting in the underlying cause given in Part I.				se contribute to t	o the cause of death?			
ord	w requir been si should	ted	Chronic Obstructiv	e Pulmona:	ry Disease	<del></del>		1[	]Yes 2□	Yes 2 No 3 Probably 4 Unknown			
	alawı hasbo e2sh	Completed	Drug induced Lupus Erythematosis 24a. Was an autopsy								24b. Were autopsy findings available prior to completion of cause of		
			Acute Renal Failur	re				pe 1 ☐ Yes	rformed? 2⊠No	death?	2 🗆 No		
Vital	Physician: This certificated director, p	o Be	25. Was case referred to medical examiner?	lospital:			OH	of Death (Check onl					
o			1 ☐ Yes 2 ☐ No ☐ ☐ 27. Manner of Death	1 Tainpatien 28a. Date of Injury	28b. Time of	OLI DOX	4 🗀 1401	sing Home 5 Re			(y)		
ion	Attending F death. ctor: After y the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?					,				
Division	Hospital or Attending 14 hours after death. Funaral Director: Afte tely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined						(Street and own, State)	Number or Rura	al Route Numb	per,	
	To the Hospital or / within 24 hours effer To the Funaral Dire completely filled in b	edicai	ane)	ician: To the best of ner: On the basis of and manner state	my knowledge, death examination and/or inved.	occurred at the vestigation, in m	e time, date and ny opinion, death	place, and due to the control occurred at the time	e, date and p	and manner as s place, and due to	tated. o the cause(s)		
	with To To To To To To To To To To To To To	Σ	29b. Signature and title of certifier  Milbael a. 7	12110	M A		ense number 52451			signed (Month,	•		
,	K		•		- '/		, <u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>		Whill	25, 200	J4 		
	-		30. Name and address of person who co Michael A. Western				Dileo 4	102 D1		W 1	1		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		-		TUD, KOCK	vттте	, maryla	ina 208	152	
	Registr		APR 2 8 200	4 Dens	was B	Loans	End						

			1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		ene2004 15250		
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  John Adam Huies	s		2. Date of Death Month April	Day Year 25, 2004 9:24 a.M		
)	Examir		4a. Facility Name (If not institution, give s Washington Advent	ist Hospital	4b. City, Town, or Location of Deal Takoma Park		4c. County of Death  Montgomery		
k	Funeral Director		5. Social Security Number 6. Sex 577-58-4912  Usual Residence of Decedent	M 2 F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min		Year) 9. Birthplace (State or Foreign Country) 1910 Jersey City, NJ		
	a-f show	ctor	10a. State 10b. County  Maryland Prince Ge	10c. City, Town or Lo eorge's Adelph			10d. Inside City Limits 1 ☐ Yes 2 ဩ No		
	with the	Directo	10e. Street and Number	o.4 #25	10f. Zip Code 20783	10	g. Citizen of What Country?		
136	hours after death with the Maryland tural; or Items 23a or 28a-f show al Examinat Innal bornvilllad at	by Funeral	1820 Metzerott Ros  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	Vas Decedent of Hispanic Origin? (§ f Yes, specify Cuban, Mexican, Puer t ☐ Yes 2 ☒ No Specify:	Specify Yes or No- to Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: White		
Maryland 21215-0036	within 72 houlene. Than "nature	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Completed) (Give life. I	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) Dyment Officer	rking 1	6b. Kind of Business/Industry U.S. Dept. of Agriculture Federal Government		
yland	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)  John Huiess		18. Mother's Na Kathe	me <i>(First, Middle, M</i> rine Hehi	aiden Sumame) ner		
lore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is merked other than "natural, or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examination must be rediffied at once.		19a. Informant's Name/Relationship (Type Helen B. Huless/ 120a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Re	Wife 1820  20b. Place of Dispo	natory or other place) Ap1	#35, Adel Date 2 11 29,	phi, MD 20783 Oc. Location - City or Town, State		
Baltimore,	permit. Pa Departmen Important: sny injury once.		*4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	Gate of Camera Fr. 50	etery .Name and Address of Facility Cancis J. Collins	Funeral	Home Inc. lver Spring, MD 20901		
)	Pnysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not ent e cause on each ine.  Due to (or as a consequence of):	1 1	or respiratory arres	st, Approximate Interval Between Onset and Death		
8760,	I necords, r.O. box or The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertains Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):					
O. Box 68		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		
rds, P.		by	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.		id tobacco use contribute to the cause of death?		
al Reco		Completed				24a. Was an autopsy perform			
ysician: The rise certificate director, pag	To Be	25. Was case referred to medical examiner?  1 Pres 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	ath <i>(Check only one</i> Home 5 ☐ Residen				
ion of	Attending Phy death, ctor: After this y the funeral o		27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			Residence 6 Other (Specify) ribe how injury occurred		
Division	O	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str. building, etc. (Specify)		City or Town,	ion (Street and Number or Rural Route Number, or Town, State)		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, death ter: On the basis of examination and/or inv and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as stated. se and place, and due to the cause(s)		
b	.0	Me	29b. Signature and liftle of pertifier		29c. License number 45 7 0 3	29	d. Date signed (Month, Day, Year)		
	γ		Stephen M.	mpleted cause of death (Item 23a) (Type,	Print)	le Rd., Si	lver Spring, MD 20910		
, .	Sta Regist		31. Date filed (Month, Day, Year) APR 2 8 200	32. Registrar's Signature	Locales		2 0.		

#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Lest) George Stanley Month 04 2004 Harvey 27 4c. County of Death 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) Garrett County Memorial Hospital Oxiciand Garnett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 7 Birthplace (State or Foreign Country) 5. Social Security Number 7, Age (In yrs. lest birthday) Deys 152 M 2□ F Yrs. MD 81 218 16 3686 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Swanton Garrett 10f Zin Code 10g. Citizen of What Country? 10e Street and Number USA 21561 122 Mt. Zion Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education . (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Coa1 Coal Miner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Mary E. Tichinel Randolph Harvey 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Swanton, MD 21561 122 Mt. Zion Rd. Dale Harvey 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Apr 30,04 Mt. Zion MD Mt. Zion Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licansee David A. Burdock FH 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, sprock, or heart failure. List only one cause on each line. 21538 Kitzmiller, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 → Onknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy No No 1 ☐ Yes 2 ☐ No 1 🗆 Yes 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

signed by the ettending physicien end d be deteched for use as the bunel-transit The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, sete hes been signated to page 2 should to To the Hospital or Attending Physician: The lew within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

2

Physician/Medical Examiner

Completed by

Be

Certification: To

edical

**Funeral** 

Director

e filed within 72 hours efter death with the Meryland al Hygiene. other than "natural", or tierns 23a or 28s-1 show

permit. Peges 1 and 2 should be fite
Department of Heelth and Mental Hy
Important: if Nem Z7 is marked othe
any injury or other traumette

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or flams 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1□ Yes 2□ No 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exemples: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner steted. 29a. Certifier 29b. Signature and title of pertif 29c, License number 29d. Date signed (Month, Day, Year) 4,27,04 D23979

State Registrar 31. Dete filed (Month, Day, Year) APR 2 8 2004

Dr. Robert Goralksi,

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

311 North Fourth Street, Oakland, MD 21550

Constance   Frace Mode, Asset   Constance   Constanc				For State	State of N	Maryland / De	partment of Fertificate of	Health and Me		- 43	4 15252	
Securing the Constrance K. HURLEY  45. CRITCH OF APRIL 30 2004 7:53 AM  45. Facility Name or are and number)  46. CRITCH HILLS NUMBERS (For Asstrations parts and number)  47. April 13 Wiles 1 Name 1 (April 24 Histo)  48. CRITCH HILLS NUMBERS (For Asstrations parts and number)  48. CRITCH HILLS NUMBERS (For Asstrations parts and number)  49. Special Hills Number 1 (April 24 Histo)  49. Special Hills Number 1 (April 24 Histo)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and number)  40. CRITCH HILLS NUMBERS (For Asstrations parts and numbers of the Asstration parts and numbers and numb					lle, Last)				. Date of Death			
CORSICA HILLS NURSING HOME  Foundation  Fo	8 6		94.							2004	7:53 AM M	
Secretary   Town   The property   Town   T		Examin	er									
The contract of the contract	ANC			218-20-5775			Months Days	Hours Min.	(Month, Day, Y			
12. Father's Name (First, Middle, Last)   13. Mother's Name (First, Middle, Makien Sumame)   14. Mother's Name (First, Middle, Makien Sumame)   15. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address of Pacility   16. Making Address of Pac	land	MQ III	-		у	10c. City, Town or	Location				10d. Inside City Limits	
12. Father's Name (First, Middle, Last)   13. Mother's Name (First, Middle, Makien Sumame)   14. Mother's Name (First, Middle, Makien Sumame)   15. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address of Pacility   16. Making Address of Pac	э Магу	a-1 sh iffied s	ctor	MD QUEE	N ANNE'S	CEN	<b>TREVILLE</b>				1 <b>X</b> Yes 2 □ No	
12. Father's Name (First, Middle, Last)   13. Mother's Name (First, Middle, Makien Sumame)   14. Mother's Name (First, Middle, Makien Sumame)   15. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address of Pacility   16. Making Address of Pac	with the	bene	Dire						100		Country?	
12. Father's Name (First, Middle, Last)   13. Mother's Name (First, Middle, Makien Sumame)   14. Mother's Name (First, Middle, Makien Sumame)   15. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address of Pacility   16. Making Address of Pac	death	ms 23.	eral		12. Was Deceder				fy Yes or No-		nencan Indian,	
12. Father's Name (First, Middle, Last)   13. Mother's Name (First, Middle, Makien Sumame)   14. Mother's Name (First, Middle, Makien Sumame)   15. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address of Pacility   16. Making Address of Pac	036 ours atter	el', or ite	þ		rried 1 □ Yes 2 2	§No .			can, etc.)			
12. Father's Name (First, Middle, Last)   13. Mother's Name (First, Middle, Makien Sumame)   14. Mother's Name (First, Middle, Makien Sumame)   15. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address (Street and Number or Numl Route Number, City or Town, State, Zip Code)   16. Making Address of Pacility   16. Making Address of Pac	15-0	"natu	letec	15. Decede (Specify only high	nt's Education est grade completed)	(G	ive kind of work done	during most of working	16	b. Kind of Busines	ss/Industry	
1   Marial   2   Cremation   3   Removal from State   MARYLAND   VETERAN CEMETERY   HURLOCK, MARYLAND	2121 I withir	them the Ma	omp			r 5+)		0)		REAL EST	'ATE	
1   Marial   2   Cremation   3   Removal from State   MARYLAND   VETERAN CEMETERY   HURLOCK, MARYLAND		d othe		· ·		<del></del>		19.50				
1   Marial   2   Cremation   3   Removal from State   MARYLAND   VETERAN CEMETERY   HURLOCK, MARYLAND	ryla nould b	narke natic	ဥ			10h M	nilian Address (Street				7:- 0-4-1	
1   Marial   2   Cremation   3   Removal from State   MARYLAND   VETERAN CEMETERY   HURLOCK, MARYLAND	, Malanda Selft and 2 sl	n 27 is r		DAVID A. KELLE		922	THOMPSON	CREEK ROAD	, STEVEN	ISVILLE,	MD 21666	
Physician / Medical Examiner  Physic	imore Pages 1	ant: If Ite		1 XBurial 2 Cremation		e cemetery, o	rematory or other pla			·		
Physician Medical Examiner  Ph	Balt permit.	Import sny inj once.		21. Signature of Funeral Service	Licensee	heri !	22. Name and Addre FELLOWS, HE 408 S. LIB	ess of Facility LFENBEIN & ERTY ST., (	NEWNAM CENTREVI	FUNERAL LLE, MD	HOME, P.A. 21617	
The part of the	Phy	sician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	or complications that cause tonly one cause on each	ed the death. Do not line.	enter the mode of dying	ng, such as cardiac or r	espiratory arrest	i,	Interval Between Onset and Death	
The first of the f				resulting in death)	Due to (or a	s a consequence of):	( )				5.	
SOURCE STAND SIGNAL STAND STAN			Jer	if any, leading to immediate	b. Due to (or a	s a consequence ot):	abiles				70	
SOURCE STAND SIGNAL STAND STAN	ecuted	and -transi	kami	Cause (Disease or injury that initiated events	C. Due to /or e	a a consequence of						
The state of the s	8760,	hysician the burial	Jicai E		d	s a consequence or).						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No   3   Probably   4   Unknow    24a. Was an autopsy performed? 1   Yes   2   No   25. Was case referred to medical examiner? 1   Yes   2   No   25. Was case referred to medical examiner? 1   Yes   2   No   26. Place of Death (Check only one)  27. Manner of Death   1   Inpatient   2   ER/Outpatient   3   DOA   28d. Injury at Work? 28d. Describe how injury occurred	O. Box 6	or use as	a	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal death		у				
The state of Death (Check only one)  24a. Was an autopsy performed?  24b. Were autopsy findings availab prior to completion of cause of death?  1   Yes   2   No    24a. Was an autopsy performed?  1   Yes   2   No    24b. Were autopsy findings availab prior to completion of cause of death?  1   Yes   2   No    24b. Were autopsy findings availab prior to completion of cause of death?  1   Yes   2   No    25c. Was case referred to medical examiner?  1   Yes   2   No    25c. Was case referred to medical examiner?  26c. Place of Death (Check only one)  Hospital:     Inpatient   2   EP/Outpatient   3   DOA    27c. Manner of Death	S that	ned by e deta		Part II. Other significant condit	ions contributing to death	but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute	to the cause of death?	
24a. Was an autopsy findings availabe prior to completion of cause of death?  1	ords	en sig	ted t				<del> </del>		1 ☐ Yes	2)ENo 3□	Probably 4 Unknown	
25. Was case referred to medical examiner?  1		2 5	Comple						autopsy performe	d? prior to	completion of cause of	
1   Inpatient 2   EN/Outpatient 3   DOA   Market   Security    27. Manner of Death   Security   Sec	Vita	certitic rector.	Be	examiner?	Hospital:	-5	Oth	000		-	-	
To the state of th	P F	er this ieral di		27. Manner of Death	28a. Date of In		IGHT 30 DOX	4 LENGISING HORIE			ecify)	
	iSiOr ttendin death.	or: Att	catio	Accident investigation   Montal, Day rear/   Injury   Work?								
3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide  28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	Division Att	Direct d in by	ertific	doton	nined 288. Place of I	njury - At home, farm, etc. (Specify)	street, factory, office	281			Rural Route Number,	
The state of the s	e Hospite	• Funeral		(Check only 2 Medica	Examiner: On the basis	of examination and/or	eath occurred at the tire investigation, in my o	me, date and place, and opinion, death occurred	d due to the caus at the time, date	se(s) and manner a and place, and di	as stated. ue to the cause(s)	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	To th	To th	Me	29b. Signature and title of certifi		Church	,				nth, Day, Year)	
30. Name and address of person who completed lause of death (Item 23a) (Type, Print)	5 V	v I			who completed ause of	death (Item 23a) (Typ	pe, Print)	. 0	1	1 2		
State 31. Date filed (Month, Day, Year)   32. Registrar's Signature		Sta	te		32. Regis	trar's Signature	marks by	ine Chis	he ore	1 2/6	19	
State Registrar  31. Date filed (Month, Day, Year)  MAY = 4 20 4  DHMH 17 Rev 1/2001				MAY	- 4 2004 A	Com K	Sec. 11.					
DHMH 17 Rev 1/2001 ORIGINAL	DHMH 1	7 Rev 1/20	01			ORIGI	NAL					

		4	For State Registrar	State of Ma	ryland	•	irtment tificate			and M	R	eg. No. Z	004	15	253
i	Physici		1. Decedent's Name (First, Middle, Las JOYCE ANN HANES	st)							2. Date of Dea Month APRIL	Day	Year 2004	3. Time of I	
<del>)</del>	/Medic Examin		4a. Facility Name (If not institution, given 117 JOHNSON DRIVE				SALI	SBUR	Location o	f Death			inty of Death MICO		
	Funeral Director		213-02-2402	ex 7. Age □ M 2 F	(In yrs. la	ast birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day FEB • 27	,1952	9. Birth Coul MARY	lace (State or htry) LAND	Foreign
	Maryland -f show	_	Usual Residence of Decedent  10a. State 10b. County			, Town or Lo								0d. Inside Cit	
0	ith the Marylar or 28a-f show	Director	PA BUCKS  10e. Street and Number			LEVITT	10f. Zip	Code			1	l0g. Citizen	of What Cou		
イン	death with		40 NEWBERRY LANE						054	10/0			USA		
030	urs after dea al', or Items Evention	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates:			Vas Deced Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		Race - Americ Black, White, ec <i>ify:</i> WI		
1215-0036	I within 72 hours after death with the Maryla jiene. Then "natural", or Items 23a or 28a-1 shov The Wedical Examinar must be mailified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1.2	lucation de completed) College (1-4or 5-	+)	life. D	lent's Usua kind of wor DO NOT us EMAKE	k done di e retired)	uring most	of worki	ng	16b. Kind o	of Business/In	dustry HOME	
yland 2	be filed stat Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last, OLIN CHARLES NEW						18. Mothe		CAS LEE				
Mar	s 1 and 2 should t Health and Mer item 27 is marke other traumatic	•	19a. Informant's Name/Relationship ( JOHN M. HANES/HUS				•				TOWN, E			Code)	
Baitimore,	e = 5		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 6 Other (Specif		ce	ace of Disposemetery, crem	natory or of	her place					on - City or To	wn, State	D
Бапп	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licer		les	Z <sup>22</sup>	Name and LLER	FUNE	s of Facilit	HOME	, P. O. ROAD, S	вох з	171		
	Physician /Medical Examiner and pruisitions an	Examiner	23a Part 1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or a) c. Due to	consequi	ence of):	1 /		, such as	-4	or respiratory arr			Approximate Interval Betwo	reen
O. Box 68/60	The law requires that the death certificate be seen signed by the attending physicial page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 25 No	23c. If yes, outcome of the control	2 Fetal	death 3	Ectopic pro					23d.	Date of delive	-	ear
ds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of	contributing to death bu	t not resu	Iting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to			ne cause of de	
Vital Records,		Completed										med? 2XLNo	tb. Were auto prior to co death? 1 \( \sum \section \) Yes	psy findings ampletion of ca	vailable use of
ō	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	on: To Be	25. Was case referred to medical examiner?  1 Yes 25 No  27. Manner of Death	Hospital: 1 Inpatier  28a. Date of Injury (Month, Day)	v T	ER/Outpatien 28b. Time of Injury	2	8c. Injury Work	r: 4 □ Nu at ?	rsing Hor	n (Check only or me 5 ☐ Reside 28d. Describe he	ence 6 🗹		ysisteri k	Peri Line
Division	To the Hospital or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fo	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 29a Place of Jain	ry - At ho . (Specify	me, farm, stre	M eet, factory		′es 2 □ f		28f. Location (S City or Town		umber or Rura	l Route Numb	per,
	To the Hospital or At within 24 hours after or To the Funerel Directompletely filled in by	edical (	29a. Certifier (Check only one) Certifying Pt	nysician: To the best of niner: On the basis of and manner stat	examinat	wledge, death ion and/or inv	occurred a	at the tim in my op	e, date an inion, deal	d place, a	and due to the c ed at the time, d	ause(s) and ate and pla	I manner as s ce, and due to	ated. the cause(s)	
)	To th within To th comp	Me	29b. Signature and title of certifier	W			290	. License	number	5	2	9d. Date si	oned (Month,	Day, Year)	
			30. Name and address of person who Toseph H. Grasse	mi	145	E. Ca		St.,	A-1	Si	alisbury	MD	2180	<i>i</i>	
被	Sta Regist		31. Date filed (Month, Day, Year) APR 2 7	32. Regultra	r's Signat	rure A	Local	J			/ /				

		1 - For AMEND#10-perTNF State Registrar AMEND#19-perTNF	State of Marylan 5/3/04,BW,Mcc 5/3/04,BW,Mcc	d / Depa	rtificate of	Death	Mental Hyg  F  2. Date of Dea	giene Neg. No. 2	004	1525
Physicia /Medic Examin	an al er	Leonard Jasper  4a. Facility Name (If not institution, give s  Potomac Manor C	are		Potoma			4c. Coun Mor	Year ty of Death	6:00 A <sup>M</sup>
Funeral Director		5. Social Security Number 6. Sey 1	M 2□F 76	Yrs.  y, Town or Lo	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 11-26-1	r, Year)		place (State or Foreign htty)  NY  NO. Inside City Limits
the Maryla r 28e-1 show	Director	MD Montgom  10e. Street and Number	ery Roe	Ciase kville	10f. Zip Code			10g. Citizen of		1 ☐ Yes 2 🗖 No
er death v Items 23s	ra .	4615 N. Park Ave.  11. Marital Status  1 □ Never Married 2 ⅓ Married	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No	S. 13.	2( Was Decedent of H If Yes, specify Cuba	0815 Ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	U.S.A.	ice - Americ ack, White,	
Permit. Pages 1 and 2 should be filed within 72 hours at Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Example.	þ	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade		16a. Dece	1 ☐ Yes 2 ☑ No  dent's Usual Occup kind of work done of DO NOT use retired	during most of wor	king	Special Specia	WII.	
be filed within tal Hygiene. d other than "	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		tile Cons	ulant 18. Mother's Nan	ne (First, Middle,	Maiden Suma	те)	
d 2 should be th and Mental 7 is marked fraumatic ev	오	Ezekiel Jasper  19a. Informant's Name/Relationship (Ty Jane Jasper -Wife		19b. Mailir 4615	ng Address (Street N. Park	Bertha land Number or Ru Ave. Roel	ral Route Number	r, City or Town	n, State, Zip	Code)
permit. Pages 1 and 2 should be Department of Health and 2 should be Important: If item 27 is markent any njury or other traumatic enones.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, crei	N. Park Park Park Park Thatory or other place The Park	Chev 4-26		20c. Location		wn, State
permit. Depertin Importa any inju		21. Signature of Funeral Service Licens	Donnell	11	2. Name and Address	n lampshire	lines-Rin	lver S		MD 20904
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Due to (or as a consequence)	Coron	ary Arter					Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	). Due to (o, as a conseq	uence oi).	cholester				1	10 yrs 10 yrs
9 9 5	cal	that initiated events resulting in death) Last	Due to (or as a consequ	uence of);	tension te M 11i					10 yrs
the death certificate by the attending physic ached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			1	ate of delive onth	ery Day Year
hat od b	þ	Part II. Other significant conditions cor	stributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to.	_	ntribute to th	ne cause of death? ably 4 []Unknown
The law ate has b page 2 si	Completed	25. Was case referred to medical						med? 2x No	Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of 2 No
ding h. Afte fune	ation: To Be	examiner?	ospital: 1  Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injun Worl	er: 4 Nursing H	ome 5 Reside	ence 6 □Ot		()
in Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	v) 			28f. Location (Si City or Town	n, State)		
To the Hospitel within 24 hours a within 24 hours completely filled completely filled	Medical	29a. Certifier (Check only one)  1 C-Certifying Physical Examinates (Check only one)  2 Medical Examinates (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at the tin vestigation, in my o	pinion, death occu	rred at the time, d	ause(s) and mate and place.  9d. Date signs	and due to	the cause(s)
3		30. Name and address of person who co	than-	23a) (Tune	D00	053615			1 26,	
		Aruna S. Nath  31. Date filed (Month, Day, Year)		Rockvi			kville,	MD 208	52	

			1 - For State Registrar	State of Marylan	-	artment of H rtificate of L			Reg. No. 2 (	104	15255
	Physici	an	Decedent's Name (First, Middle, Last,     NORMAN BERAN					2. Date of Dea	Day	Year	3. Time of Death
\	/Media	al	NORMAN BERAN  4a. Facility Name (If not institution, give	JETTMAR street and number)		4b. City, Town, or	Location of Deatl	April	26 2 4c. County	2004 of Death	10:00P <sup>M</sup>
	Examir	er	924 Childs Point			Annapo			Anne	Arund	le1
	Funeral Director		5. Social Security Number 6. Sec 12 12 12		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day July 7	v, Year)	9. Birthpl Count Wash	ace (State or Foreign lry) ington, DC
	rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
	e Man Ba-f sh Lifted	ctor	Maryland Anne Arun	del A	nnapo1	is					1⊠Yes 2 No
	with th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \		try?
	s 23	eral	924 Childs Point	Road  12. Was Decedent Ever in U	S. 13.	21401 Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-	U.S.	A •	an Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minjory or other traumatic event, I'm Medical Exam to that the modified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ No 12/ If Yes, Give Year or Dates: 12/19	1934	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	o Rican, etc.)	Blac	ck, White, e v: Whi	etc.
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupa	during most of wor	rking	16b. Kind of B	usiness/Ind	ustry .ng Products
121	within ene. than	duic	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	-	DO NOT use retired ty Contro		1	Manufac		0
ם 2	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)		, <b>Q</b> = ===			ne (First, Middle,	Maiden Suman	7e)	
ylar	Menta Menta arked atic e	To	Emil Jettmar					Beran			
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (T) Eric B. Jettmar/Se			ng Address <i>(Street a</i> Ea <b>rl</b> e Brai					and 21617
ē,	Healt Healt tem 2		20a. Method of Disposition		A STATE OF THE PARTY OF THE PAR	sition (Name of matory or other place		Date	20c. Location -		
OE E	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	Tellioval IIOIII State		Heaven Cei	'05/0	1/2004	Silver	Sprin	g, Maryland
Baltimore, Maryland	permit. Departmimporta sny inju		21. Signature of Funeral Service Licens		22 H	Name and Address INES-RINA 1800 New 1	s of Facility	RAL HOME	, INC.		20904
	Physician /Medical Examiner physician and physician ille printial-fransit	ical Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	me cause on each line.  a Metastatic Due to (or as a conseq b. Gastric Can Due to (or as a conseq c. Due to (or as a conseq	Cancer uence of): cer uence of):		y, 50011 23 curduc				Approximate Interval Between Onset and Death
.O. Box 68760,	ath certific ttending p or use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	Ideath 3[	Ectopic pregnancy Other (specify)			1	te of deliver	ry Day Year
<u>P</u>	res that the de igned by the a be detached f	/ Phy	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
rds	96 g	ed by						1 🗆 Y	es 2₺ No	3 Proba	ably 4 Unknown
Record	has b	Completed						24a. Was autop	med?	Were autop prior to com death? 1 ☐ Yes	esy findings available apletion of cause of
Vital	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	11				ath (Check only o			
o	ding Phys h. After this funeral din	ition: To	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	28c. Injury Work	at	lome 5 X Resid 28d. Describe h			)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the funeral process.	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, str	reet, factory, office		28f. Location (S City or Tow	itreet and Numb m, State)	er or Rural	Route Number,
	ne Hospitt 124 hours 1e Funera Hetely fille	edical C	29a. Certifier 1 💢 Certifying Phy (Check only one) 2 Medical Exami	rsician: To the best of my kno iner: On the basis of examina and manger stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	e, and due to the curred at the time, c	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
	F 3 F 8	M	29b. Signature and title of certifier	- //	1001	29c. License		- - -	29d. Date signe		
	5		30. Name and address of person who co	Ompleted cause of death (fren	n 23a) (Tyne	D 5330	Jb		April 2	8, 20	04
_			Curtis Harris, M	1.D., 888 Best	gate R		e #211,	Annapoli	is, Mary	land	21401
	Sta Regist		31. Date filed (Month, Day, Year) APR 29 20	32. Registrar's Signa		Sparks					

			For State Registrar			d / Depa	artment of H	ealth and I	Mental Hyg	•	
			Decedent's Name (First, Middle,	Last)					2. Date of Deat	h	3. Time of Death
	Physicia /Medic		Dok Yun Jin						Month 4-24-0	A Day Ye	4:30 A. M
i.	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or	Location of Death	1	4c. County of [	)eath
Н			Casey House				Rockvil			Montgo	
	Funeral Director		5. Social Security Number 212–17–8669  Usual Residence of Decedent	. Sex 7. Ag 1⊠M 2□F	e (In yrs. I 52	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 5–18–51	Year) 9.	Birthplace (State or Foreign Country) Orea
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	within 72 hours after deeth with the Maryland ene. than "naturel", or items 23e or 28e-f show the Madical Examiner must be notified at	호	MD Montgo	nme <i>r</i> w	Sil	ver Sp	ring				1 □ Yes 2 ☑ No
	7 28e	Funeral Director	10e. Street and Number	omery	DIL	VCI DE	10f. Zip Code		10	0g. Citizen of Wha	t Country?
	3a o	0	13112 Fernedge	Rd.			209	06		Korea	
	deet	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. \	Was Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Race - /	American Indian, White, etc.
9	after or ite		1 ☐ Never Married 2 🔀 Marrie				1 ⊡Yes 2 ⊠ No		riioan, etc.)		
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates:						Specify: A	
5	"natu	ete	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	lent's Usual Occup: kind of work done o DO NOT use retired	ation during most of wor	king	18b. Kind of Busin	ess/Industry
4	withir	Completed	Elementary/Secondary (0-12)	College (1-4or :	5+)		employee			Roofe	r
9	filed Hygid ther ant, I		17. Father's Name (First, Middle, La	ist)					ne (First, Middle, N		
an	ld be ental ked o	To Be	Chun Jin					Sun Yu	1		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23a or 28e-f show any injury or other treumatic avent, the Madical Examiner must be notified at once.	-	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, Sta	te, Zip Code)
Š	alth a alth a 27 is		Tae Ja Jin - V	Wife		13112	Fernedg	e Rd. Si	lver Spri	ing, MD 2	.0906
ore,	item 1		20a. Method of Disposition	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. P	lace of Dispo	sition (Name of natory or other place	e)	Date 2	20c. Location - City	or Town, State
Baltimore,	Page In Fire E		1 ☑ Burial 2 ☐ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe			ate of	Heaven C	em. 4-2		-	oring, MD
a	ppartr portr y inju		21. Signature of Funeral Service Li	censee			. Name and Addres	-			
_	82.5 8 9		Muane (	a Coff	elle	r				-	ing, MD 20904
	Pnysician		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition				er the mode of dyin		or respiratory arre	est,	Approximate Interval Between Onset and Death 6+ months
	/Medical Examiner		resulting in death)	Due to (or as							
	Examine	L	Sequentially list conditions,	b							
	ed isit	Examine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that in interest and the content of the co	Due to (or as	a consequ	dence or):					
	xecut and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):					
760,	ficate be executed physician and is the burial-transit	calE		d							
99	ificate g phy as the	B		u.							
Вох	death certifica e attending ph d for use as th	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy			23d. Date of	•
	that the death certifica ed by the attending ph detached for use as th	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐Unknown			Other (specify)			Month	Day Year
P.0	that the led by the detache	Phy	9 Unknown			101 - 1 - 11		1.0.4	22- 0:44-6		
	ires tha signed d be det	by	Part II. Other significant condition	s contributing to death to	out not rest	uiting in the ui	nderrying cause give	en in Parti.			te to the cause of death?
Orc	w requir been si should	eted									
Records,	2 5 8	ompleted							24a. Was ar autops perform	y prior	e autopsy findings available to completion of cause of h?
<u>a</u>		O	25. Was case referred to medical						1 ☐ Yes 2	!⊠No 1□	Yes 2□No
Vital		o Be	examiner?  1 Tes 2 XNo	Hospital:	ent 2 T	ER/Outpatien	t 30 DOA Otho	ar.	th (Check only one	nce 6 🖾 Other (	Specify) Hospice
of			27. Manner of Death	28a. Date of Inju	ıry	28b. Time of	28c. Injury	at	28d. Describe ho		преспу ПОВРІСС
ion	투수동화	atlo	1   Natural 5  Pending 2  Accident investiga	(Month, Da tion	y rear)	Injury	M 1 🗆	Yes 2 No			
Division	or Attendate death Director:	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		jury - At ho	me, farm, str	eet, factory, office		28f. Location (Str City or Town		r Rural Route Number,
	Hospitei o 4 hours af Funerei D		200 Cartifica 455 Cantal	Physician Tathan	of mustice	ulades to		an Ideas and I	and distant		
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	edical	(Check only 2 Medical E:	Physician: To the best kaminer: On the basis o and manner st	f examinat	tion and/or in	vestigation, in my of	oinion, death occu	rred at the time, da	ate and place, and	due to the cause(s)
	To t To t	Σ	29b. Signature and title of sectifier				29c. License			9d. Date signed (N	onth, Day, Year)
7	6		Cester	100				0412:	48	7/24/9	77
	Ť		30. Name and address of person w							,	
	Sta	at o	Charles Harris 31. Date filed (Month, Day, Year)	on 6001 M 32. Begistr			ill Rd.	<u>Kockvill</u>	e, MD 208	352	
	Registi		APR 2 8 2		AFRICA	19	porks	P. Comments			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician April 22, 2004 Stefan Jodlowski 4:30 PM /Medical 4a Fecility Name (If not institution, give street and number) Western Maryland 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** Health System, Sacred Heart Campus Cumberland If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Poland Aug 13, 1911 Director 92 <u> 268–38–9028</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours after death with the Manylan th and Mental hyglene.
77 Is marked other than "natural", or Hems 23s or 28s-f show it? an unset o should be a should be 10a. State 10b. County 1 ☐ Yes 2 X No Garrett Grantsville Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 131 Killdeer Lane 21.536 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ 2 TNo if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: white Ş 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ years Professor of Sociology University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be flis of Heelth end Mental Hi f Itam 27 is merked oth å Julja Kopija Piotr Jodlowski 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alina Jodlowski/wife 131 Killdeer Lane, Grantsville, MD Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Peges 1 Department of H Important: If its any injury or ot pncs. 1 Burial 2 □ Cremation 3 □ Removal from State Grantsville Cemetery, Apr 27,2004 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Newman Funeral Homes, P.A., PO Box 275 21. Signature of Funeral Service Licensee 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faillire. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical septic shock 1 hour Examiner Due to (or as a consequence of): Examiner septicemia 3 weeks attending physician and for use as the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): urinary tract infection 4 weeks Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): prostate cancer 13 years Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? atrial fibrillation, pheochromocytoma, atherosclerotic 1 Yes 2 No 3 Probably 4 Unknown \$ 24b. Were autopsy findings available prior to completion of cause ol death? cerebrovascular disease 24a. Wes en autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vitai 25. Was case referred to medicat examiner? B 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ To the Mospital or Attending Phys within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral di After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) louran D0025759 April 22, 2004 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann, M.D., PO Box 247, 106 Cemetery Road, Accident MD 21520-0247 31. Date fited (Month, Day, Year) 32. Registrar's Signature APR 2 6 2004 15 Aprelle Registrar

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			1 - For State Registrar	State of Ma	aryland		artment rtificate					giene,	/ III II II II II II II II II II II II I	152	58
	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of De Month		Year	3. Time of	Death
	/Medic		William Lee K	<del> </del>	Jr.						pril	30 30	2004	2:13	Рм
	Examin	er	4a. Facility Name (If not institution, give		<del>-</del>				Location of				County of Death harles		
	Europal		9100 Block At 3 5. Social Security Number 6.5		e (In yrs. las	t birthday)	If Under		If Under		. Date of Bir	th		ace (State or	r Foreign
	Funeral Director		419-11-5795 Usual Residence of Decedent	1⊈M 2□F 24		Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)	980 Ala	try)	- Oreign
	anylan show	_	10a. State 10b. County		10c. City, 7		cation						1/	od. Inside Cit	•
	86-f s	Director	Maryland Charle	es	LaP	lata								1X Yes	2   No
	72 hours after death with the Maryland naturel', or Itame 23a or 28e-f show Alcal Exarch at most be motified at	ă	10e. Street and Number 5100 Hawthorne	n Dood			10f. Zip					-	en of What Coun	try?	
	leath	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \		2064 ent of His		gin? (Speci	fv Yes or No		S.A.	an Indian.	
ယ	or Itan		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐X						, Puerto Ri	fy Yes or No can, etc.)	- 1	Black, White,	etc.	
03	rel', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes 2	2L <b>X</b> No	Specify:				Specify:Whit	ce	
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12	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5	+)		rpent					Poc	ort Pai	-le	
<b>Q</b>	other vent, I		17. Father's Name (First, Middle, Last	)		<u> </u>	L pent		18. Mothe	r's Name (i	First, Middle,			· V	
an	ould be Mental arked o	To Be	William Lee Kr	niphfer,	Sr.				Nan	Mari	e But	ffor	đ		
Maryland	SPEE		19a. Informant's Name/Relationship (	Type, Print) Fat	her	19b. Mailin	ng Address						Town, State, Zip	Code)	
Σ,	is 1 and 2 of Health a item 27 is other trea		William Lee Kn	iphfer, "Š	r.	5100	Hawt	hor	ne R	₹d.,	LaPla	ata,	Md. 20	646	
Baltimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	e of Dispo etery, cren	sition (Nam natory or ot	ne of ther place	Mav	3 Dat	004	20c. Loc	ation - City or To exandri	vn, State	
Ë	t. Partentining		`4 ☐ Donation 5 ☐ Other (Special	<b>5</b> )	Meti	copo.	litar	า Fu	inëfa	ıI'Sē	řvíce	e Al	exandri	a, Va	ì.
Ba	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Lice	han	M0066	58 W 4	iIIia 270 F	ams Iawt	Fune horn	ral ne Rd	Home, In	P.i	A. n Head,	20640 Md.	)
	Physician /Medical Examiner purple and purpl	Examiner	shock, or hear failere. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (or as a Due to (or a) Due to	a consequen	ice of):								Interval Betw Onset and D	
P.O. Box 68760,	he death certificate be executed the attending physicien and ched for use as the burial-transit	Physiclan/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	of pregnancy 2   □ Fetal de	/ eath 3⊡	Ectopic pre					23	3d. Date of deliver Month	,	9ar
	uires that the de	by	Part II. Other significant conditions of	contributing to death bu	ıt not resultir	ng in the ur	nderlying ca	iuse givei	n in Part I.			obacco us	e contribute to the	e cause of de	
Division of Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed											death/	sy findings av	
ita	yslcien: The is certificate hadirector, page	BeC	25. Was case referred to medical						26. Place	of Death (C	Check only o		12-103		
<u>&gt;</u>	Physicien: r this certifice ral director, p	To	exeminer? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2□ER	/Outpatien		_	4 🔲 INUI	sing Home	5 🗆 Resid	dence 6	Other (Specify)	at sce	ne
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<u>&gt;</u>	or Attencater death Director: in by the	ertif	4 Homicide determined	building, etc	. (Specify)	_					City or Tow	vn, State)	Number or Rural	4.5	
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of	f my knowle	dge, death	occurred a	it the time	e, date and	d place, and	due to the	cause(s) a	nd manner as sta	ted.	270
	ne Ho ne Fu ne Fu	edical	(Check only 2 Medical Exar	niner: On the basis of and manner sta	examination	and/or inv	estigation,	in my opi	nion, death	h occurred	at the time, o	date and p	lace, and due to	he cause(s)	
	To the comp	M	29b. Signature and title of certifier	1 . 1.	2 7		29c.	License	number			29d. Date	signed (Month, D	ay, Year)	
•			Malate	The Youl	2-1	11	- 10	-(	C.M	.E.	M	May 0	1, 2004		
	RRAM	1	30. Name and address of person who	completed cause of de	ath (Item 23									201	
	AUG		MANARIA () 31. Date filed (Month, Day, Year)	KORAU 32. Registra	r's Signature		L Penr	Sti	reet,	Balt	more,	Mar	yland 21	70T	
	Sta Registr			2004			back	ø							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month Physician 29 09:50 AM Ralph E. Kendall 2004 April /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Williamsport Nursing Home Williamsport Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) | Aug. 25, 1 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** 1☑M 2□F 93 214-09-5424 Yrs. Director 1910Chambersburg PA Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydjene. Important: If them 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event. The Maryland. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Funeral Director Washington Williamsport 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street end Number USA 21795 154 N. Artizan ST 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 TYes 2 □ No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☐xNo Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Shoe Machinery 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles D. Kendall Carla B. Miner 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) George W. Kendall 10701 Oak Forrest DR Hagerstown, MD 21740 20b. Piece of Disposition (Name of complete, cremator, or other place)
cumber land Valley
Cremator ium 20a. Method of Disposition May Date 4 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Waynesboro, PA 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signatyfip of Funeral Service Licensee 50 S Broad ST Waynesboro, PA 17268 23a. Part Enter the disease, ir complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 1 week a. Preumonia Examiner Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its tool as your case) Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Heart Failure 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Renal Failure Dementia due to Alzheimers 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 6876 To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu

SOAM

April

2/1

21215-0020

Maryland

Baltimore,

State Registrar

29b. Signature and title of certifier

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Cynthia Kuttner-Sands, MD. Williamsport Nursing Home 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

anthia Kuttner - Sando, mo

MAY 1 2 2004

29c. License number

D47451

29d. Date signed (Month, Dey, Year)

April 29, 2004

154 North Artizan Street

Williamsport Maryland

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Mar	yland		rtment tificate			ind M		Reg. No	71111		15260
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last     Se     Aa. Facility Name (If not institution, give	,		K	ao 4b. City, To	own, or	Location o	f Death	2. Date of De Month April	26		ar	3. Time of Death 11:30A. M
	Funeral Director		543-86-5266			st birthday) 2 Yrs.	If Under 1		er Sp If Under 2 Hours		8. Date of Birt (Month, Da May22,		Montgo 9. To	Birthplac Country	/ ce (State or Foreign r) ng–Taiwan
	he Maryland :8e-f show	ector	Usual Residence of Decedent  10a. State  Virginia  Fairfa			Town or Lo 7ienna						10.00			1. Inside City Limits 1 ☐ Yes 2 X No
	ath with t	Funeral Director	10e. Street and Number 10326 Dunn Meadow		-		10f. Zip C	epo	2218	32			izen of What Lted St	tate	s
036	ours after dea el', or Items Exeminar m	ğ	11. Marital Status  1 □ Never Married 2 □ Married  3 🏋 Widowed 4 □ Divorced	12. Was Decedent Even Armed Forces?  1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	er in U.S	l l	Vas Decede í Yes, specif	y Cubar	spanic Orig n, Mexican Specify:	jin? (Spe , Puerto f	cify Yes or No Rican, etc.)	-	14. Race - A Black, W Specify:		c.
21215-0036	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Heatth and Mental Hygiene. Itam 27 is markad other than "naturel; or Items 23e or 28e-f show cither traumatic avant, the Medical Exerting the red	Completed	15. Decedent's Edi (Specify only highest grad			(Give life. L	lent's Usual kind of work DO NOT use	done di retired)	urina most	of workir	ng		ind of Busine	ess/Indu	stry
Maryland 2	buld be filed Mental Hygi arkad other atic avant, I	To Be C	17. Father's Name (First, Middle, Last) Lin Gung						18. Mothe		(First, Middle,	Maider	Sumame)		
	and 2 sho alth and 27 is m er traum		19a. Informant's Name/Relationship (T) Tsong-Liang Kao/								/Route Numbe /ienna,				
Baltimore,	Pages 1 aent of Hent o		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐   1   1 Donation 5 ☐ Other (Specify,		cer	netery, cren	sition (Name natory or oth shing	er place			/2004		ocation - City elphi,		
Balti	permit. Pages 1 Department of H Important: If ita any injury or ot		21. Signature of Funeral Service Licen	homas	>	D2 44	Name and nala	Addres:	s of Facility OFGW	ardt 1 Rd.	Funera Belts	l Ho	ome, P. Le. Mai	.A.	nd 20705
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a control of the control of th	De	Do not ente								A	Approximate Interval Between Onset also Death
8760,	ate be executed hysician and the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c											
.O. Box 6	ath certific ttending p or use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	d. 23c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal d	leath 3	Ectopic prec						23d. Date of Month		ay Year
ords, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions co	ntributing to death but	not result	igg in the ur	derlying cau	ıse give	n in Part I.						cause of death?
al Records,	ician: The law ricertificate has be rector, page 2 shr	Completed	Seule Des Hyperten	mentis. Sec	<i>V</i>						1 Yes	rmed? 2 No	prior death	to comp	y findings available letion of cause of
ion of Vital	ding Phys h. After this funeral dii	ation; To Be	25. Was case felf red to medical examinate   1 Yes 2 No   27. Manner of Death   1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y		R/Outpatien 28b. Time of Injury	3 DOA	Othe Linjury Work	r: 4 🗆 Nur	sing Hon	(Check only one 5 Residence Residenc	lence		maght	ter's home
Division	in the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At hom (Specify)	ne, farm, str	eet, factory,	office		2	8f. Location (S City or Tow	Street an	d Number or	Rural A	Route Number,
	To the Hospital or At within 24 hours after o	dical		vsician: To the best of r iner: On the basis of ex and manner state	xaminatio										
)	within to the comp	Me	29b. Signature and title of certifier	. m.D			01		number 23	8/3	VA.		te signed (Mo		
	Sta	te.	30. Name and address of person who c Kenneth Cheng-Nar 31. Date filed (Month, Day, Year)		. 31	2 S.	Washir			, #6	B Alexa	andr	ia, Vi	rgiı	nia 22314
	Regist		APR 3 0 200	1 Smerr	2	J	Dogo	the Locale	,						

			1 _ For State	State	of Maryla	and / Depa	artmen	t of Hea	alth and	Mental H	ygien	esun!	15261
			Registrar  1. Decedent's Name (First, Midd)	lle, Last)	<u> </u>		lincale	e oi De	zali i	2. Date of D	Reg. N	0.4	3. Time of Death
	Physic		Leonard Thom	as Kardy.	Jr.					Month April	D	ay Year	
	/Medi Examii		4a. Facility Name (If not institutio				4b. City,	Town, or Lo	cation of De			c. County of Death	7:38A M
			Shady Grove	Adventist	Hospit	tal		ville				Montgome	
	Funeral		5. Social Security Number	6. Sex		rs. last birthday)	If Under Months	1 Year If	Under 24 H		irth	9. Birth	place (State or Foreign
	Director		220-42-3203	1 M 2 □ F	58	3 Yrs.		Days	10013	Aug.			nington, DC
	land land		Usual Residence of Decedent  10a. State 10b. County	,	10c. (	City, Town or Lo	cation						10d. Inside City Limits
	Mary fied	ţō	Maryland Monte	omery	м	ontgome	war 174	11000					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	Somery	11	onegome	10f. Zip				10a. C	itizen of What Cou	ntry?
	h witi	a D	19513 Transhi	re Road			208	86				ted State	
	ams ams	by Funeral	11. Marital Status		edent Ever in	U.S. 13.	Vas Deced	ent of Hispa	nic Origin?	(Specify Yes or Nerto Rican, etc.)		14. Race - Americ	can Indian,
36	or It	y Fu	1 Never Married 2 Married	ned 1 X Yes	2 No	1	l Tes, spec I∐ Yes 2		nexican, Pue Specify:	erro Rican, etc.)		Black, White,	etc.
Ö	hour:	D D	3 ☐ Widowed 4 ☐ Divorced	Year or D	Sates: Vie	CIIaiii						Specify: W	hite
21215-0036	within 72 hours after death with the Maryland sne. then "natural", or Itams 23s or 28s-f show he Madreal Examine, must be natified at	Completed	(Specify only highe	it's Education st grade completed)		(Give	lent's Usua kind of won DO NOT us	l Occupation k done durir	n ng most of w	orking	16b. h	(ind of Business/In	dustry
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	illed Hyg othe	Be C	17. Father's Name (First, Middle,	Last)		rialiae	C1	18.	Mother's Na	ame (First, Middle		otel Sumame)	
lar	uld be Menta rked tic ev	To B	Leonard Thoma	as Kardv.	Sr.					ryn Neel		/	
Maryland	12 should be filed within in and Mental Hygiene. I is marked other then "reumatic event, the Mic.		19a. Informant's Name/Relations			19b. Mailin	g Address	(Street and				or Town, State, Zip	Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28s-f show other traumatic event, the M-direl Examiner must be notified as		Linda J. Kardy/	/Wife		1951	3 Tra	nshir	e Road	, Montgo	mer	/ Village	MD 2088
Baltimore,	of H	1	20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from	State   2.5	Place of Dispo: cemetery, cren	sition (Nami natory or oth	e of		Date 11 28,		ocation - City or To	
Ē	trant tant: jury		`4 □Donation 5 □ Other (S	pecify)	1.14	ontgome: rematori	um. I	nc.	200	4	Bet	hesda, M	larvland
Sali	permit. Pages 1 Department of H Important: If ite eny injury of otl		21. Signature on uneral Service	Licensee		22	Name and	Address of	Facility Ro	hert A	Pilmi	hrow Fun	orel Home/
	00200		Mill	. jen	1 · MOO	803 Ro	ckvil	le, M	arylan	d 20850	-280	gomery A	venue
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on e	aused the dea ach line.	ath. Do not ente	r the mode	of dying, su	uch as cardia	ac or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		rdiomy								Onset and Death
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	3 O.	e	Sequentially list conditions, if any, leading to immediate		perten (or as a conse								
	d d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>\</b>		,							
o,	an an rial-tr	Exa	resulting in death) Last	C	or as a conse	quence of):							
8760,	icate be executed physician and the burial-transit	dlcal		d									
တ		Med	IF FEMALE:										
Вох	death certifi e attending d for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	come of pregr irth 2 ☐ Fet		Ectopic pre	nancv				23d. Date of delive	ry
	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregn 9☐ Unkno	ant at time of		Other (spec				į	Month	Day Year
0.0	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	ns contributing to de	ath but not so	outling in the un	dast das as		0	00 811			
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Ö	w require been significant	ete	Diabetes								res 21		ably 4 Unknown
ě	m = 0	Completed					-			24a. Was autop	sy	prior to com	sy findings available pletion of cause of
_	sician: The certificate rector, pag		25. Was case referred to medical								rmed? 2 □ No	death?	2□ No
>	Physician: this certific ral director,	o Be	examiner?	Hospital:	npatient 2	758/0		Oth		ath (Check only o			
	g Phys er this eral di	H 1	27. Manner of Death		of Injury h, Day Year)	ER/Outpatient 28b. Time of		4	☐ Nursing F	dome 5 ☐ Resid		Other (Specify)	)
0	Attanding I r death. actor: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investig		h, Day Year)	Injury	М	Unjury at Work? 1 ☐ Yes	2  No			, 00001100	
UIVISION	afor Attano after death Diractor:	if	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place	of Injury - At h	nome, farm, stree	et, factory, o	office		28f. Location (S	Street and	d Number or Rural	Route Number.
5	rs after al Dire	Certification:	- I Tomodo	Dulldli	ng, etc. (Speci	ny)				City or Tow	m, State,		
		edical	29a. Certifier 1 Certifying	g Physician: To the	best of my kn	owledge, death	occurred at	the time, da	ite and place	and due to the	ause(s)	and manner as sta	ited.
	the hin 24 the F			Examiner: On the ba and mann	er stated.	ation and/or inve	istigation, ir	ny opinior	, death occu	irred at the time, o	date and	place, and due to t	the cause(s)
		Σ	29b. Signature and title of certifier	00	and the		29c. l	Jicense num		2	29d. Date	signed (Month, D	Pay, Year)
	10+1	-	Danis (	Let				54	619		Apr	il 27, 20	004
			30. Name and address of person v						<i>n</i> =				
	Stat	0	Dennis Winte: 31. Date filed (Month, Day, Year)		141 Th	nomas Jo	nnson	Driv	e, #20	00, Frede	ricl	k, Maryla	and 21702
	Registra	•	APR 282	2004	pared	B	Spor	Kal					

			1 - State Registrar	tate of Marylan		artment of H			iene g. No. 2001	15262
	Physici		Decedent's Name (First, Middle, Last)  Leland M. Kane					2. Date of Death Month April 2:	n Day Year	3. Time of Death 5:49 A. M
	/Medic Examin		4a. Facility Name (If not institution, give stre Suburban Hospit	·		4b. City, Town, or Bethes			4c. County of Dea	uth
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 88	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 5,	Year) 9. Bi	nthplace (State or Foreign ountry)
	Maryland I-f show	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgomery		y, Town or Lo	ocation				10d. Inside City Limits  Types 2 □ No
	with the 3a or 28a	Funeral Director	10e. Street and Number 5225 Pooks Hill Road	, # 413 Nor	th	10f. Zip Code 20814		10	Og. Citizen of What C	ountry?
36	be filed within 72 hours after death with the Maryland hat hygiene. Id other than "natural", or flems 23a or 28a-f show of other than "natural", or flems 23a or 28a-f show event, I'm Medical Evaninar must be rodified at	by Funera	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? 1 Types 2 No Arm If Yes, Give Year or Dates: WW 2	37	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	te, etc.
21215-0036	e filed within 72 hou al Hygiene. other than "natura vent, I. a. Medical	Completed	15. Decedent's Educati (Specify only highest grade oc Elementary/Secondary (0-12) 12 Years		(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired, chant	uring most of work	sing	Jewe1rv	s/Industry
and 2	d be filed ntal Hygi ed other	Be	17. Father's Name (First, Middle, Last)  Samuel Cohn		1101			e (First, Middle, M		
Maryland	2 should be and Mental is marked creumatic even	T <sub>o</sub>	19a. Informant's Name/Relationship (Type, Marcia T. Kane –		1	-	nd Number or Rui	al Route Number,	City or Town, State,	
	permit. Pages I and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other treumatic evonce.		20a. Method of Disposition  1 Burial 2 Cremation 3 Rem	20b. F	lace of Dispo emetery, crea	sition (Name of natory or other place	9)	Date 2	20c. Location - City of	Town, State
Baltimore,	permit. P. Departme Important eny injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Dem	, 22 D	m. Garden 2 Name and Addres anzansky- 170 Pocky	s of Facility Goldberg	Memorial	Olney, Mar l Chapels, ille, Mary	Inc.
	Physician		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ons that caused the degrades on each line.	n. Do not ent	er the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death Anounce
	/Medical Examiner	ner	Sequentially list conditions, b. — cause. Enter Underlying Cause (Disease or injury	Due to (Irlas a conseq Septice)	nia	, _				2 hours
8760,	cate be executed physician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	Pulmon	ary Fib	rosis		Tweets
O. Box 6	the death certifi y the attending ched for use as	Physician/Med	IF FEMALE: 23c. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Fete 4 Pregnant at time of d 9 Unknown	ideath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
<u>α</u>	w requires that the bear signed by should be detact	by	Part II. Other significant conditions contrib	uting to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did tob		o the cause of death?
al Records,	The law ate has b page 2 s	Completed	<b>V V</b>					24a. Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
on of Vital	ding Physician: Th h. After this certificate funeral director, pag	tion: To Be	Tag talaidi a Life on aniig	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursing Ho	th (Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Spe	ecify)
Division	el or Attending s after death. Il Director: After id in by the fune	Certification:	2 Suiside 6 Could not be	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)			28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai (	29a. Certifier Certifying Physici (Check only one) 2 Medicel Examiner	en: To the best of my known to the basis of examination and manner stated.	wledge, deati tion and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
-	To the To the comple	Me	29b. Signature and title of certifier	to MO		29c. License	number /1/5	29	d. Date/signed (Mon	th, Day, Year)
i	2)	,	30. Name and address of person who comp	leted cause of death (Item	23a) (Type,	Print) 14 Ward R	and Ru	thoso.	MD 208	77
Ī	Sta Registi		31. Date filed (Month, Day, Year) APR 2 7 2004	32. Registrar's Signa	iture &	Sparks	1	· Legg	1.0 000	. /

Kame, beland Time of Death 1549

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 21, Day 004 **Physician** Herman S. Kessler 8:44 P.M /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth Aug. 15, 1928 Funeral Birthplace (State or Foreign Country) 1√2 M 2□ F Days Hours Min. 75 Yrs Director 579-28-3336 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Director 1√ Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 U. S. A. 8619 Bunnell Drive or items 23e Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 X Yes 2 No Navy Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ If Yes, Give Year or Dates:1952-1954 Specify: 3 Widowed 4 Divorced White "netural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within 7 al Hyglene. I other than "n Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 Is marked out Be Morris Kessler Gussie Page ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris B. Kessler - Wife 8619 Bunnell Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mount Comfort 4/23/2004 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disease **Physician** Coronary /Medical Due to (or as a consequence of): Examiner trrhuthmia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? 25 No 1 Yes 2 No 1 TYes Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 Emergency Physician 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) Barton POPULO Suburban Betwesda, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

APR 27

2004

hessier, Herman

		For State Registrar		of Maryla		artmen rtificat			and M	ental Hygi	ene g. No. 2 (	04	15264
Physicia /Medic		1. Decedent's Name (First, Middle, John Thomas	Last) Kinkel							2. Date of Death Month April 26	Day 200		3. Time of Death 4:15 P M
Examine		4a. Facility Name (If not institution, 2209 Gaywoods Co	urt				S	Location o	Spr		4c. County	ntgo	
Funeral Director		5. Social Security Number 131-20-4166  Usual Residence of Decedent	i. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yr. 81	s. last birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Sept. 28	, 1922	9. Birthp Cour New	place (State or Foreign ntry) York
death with the Maryland ms 23a or 28a-1 show I must be notified at	tor	10a. State 10b. County Maryland Montg	omery	10c. (	City, Town or Lo	ocation 1ver	Spri	ng				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the 23e or 28	al Directo	10e. Street and Number 2209 Gaywoods	Court			10f. Zip		906		10	g. Citizen of V		ntry?
s after dea	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☑ Widowed 4 ☐ Divorced	Armed Fo	edent Ever in orces? 2 TNo ve X	1	Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cfy Yes or No- Rican, etc.)		ck, White,	can Indian, etc. White
paritimore, interview A 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event. Its Medical Examinational perceiting any once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		(Give	dent's Usua kind of wo DO NOT us	rk done d se retired,	fu <i>ri</i> ng most )	af workii	ng 1	6b. Kind of B		dustry
Idilo Ail Ild be filed wi Iental Hygien Ked other th	To Be Cor	17. Father's Name (First, Middle, La John Adam Kinke				Journ	alls	18. Mothe		(First, Middle, M		7 <del>0</del> )	levision rien
and 2 shou alth and M 127 is mar ar traumat		19a. Informant's Name/Relationshi								/Route Number, Silver S			Code)
Dallillore, bernit. Pages 1 at Department of Hea mportant: If Item nny injury or othe	and the second	20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 1 ☐ Donation 5 ☐ Other (Spe		State	Place of Dispo cometery, crei	osition (Name matory or o	ne of ther place remai	e) tory	□ 4 <b>–</b> 28:		Oc. Location -	City or To	
permit Depart Import any inj once.		21. Signature of Foreral Service Li	300	Bo	$\bigcap_{1}^{2i}$	2. Name an 1800 ]	d Addres	s of Facility Hamps	Hin hire	es-Rinal Ave., S	di Fun ilver	eral	Home, Inc.
Physician /Medical Examiner	4	23a. Part: Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Cl Due to	nronic (or as a conse	Obstru	ctive	Pu1r						Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	Ilcal Examiner	figure that the condition of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a conse	equence of):								
the death certific	Physiclan/Med	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 ∏ Fe nant at time of	tal death 3	]Ectopic pr ] Other (sp					23d. Dai	e of delive	nry Day Year
igne bed	ρ	Part II. Other significant condition	s contributing to d	eath but not re	esulting in the u	nderlying c	ause give	n in Part J.					ably 4 Unknown
The larate has	Completed									24a. Was an autopsy perform	ęd?	Were autoportor to condeath?	psy findings available inpletion of cause of
- & SP	atlon: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending investiga	28a. Date (Mon	Inpatient 2 of Injury th, Day Year)	ER/Outpatier 28b. Time o Injury	7 -	8c. Injury Work	r: 4 □ Nur	rsing Hon 2	Check on one ne 5 K Resident Red. Describe how	ce 6 □Oth		1)
tal or Attending tal or Attending rs after death. al Director: Afte ed in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 280. Place	of Injury - At ing, etc. <i>(Spe</i> d	home, farm, str	eet, factory	, office		2	8f. Location (Stre City or Town,	et and Numb State)	er or Rura	l Route Number,
he Hospi in 24 hou he Funer pletely fill	Medical	(Check only 2 Medical Ex	Physician: To the caminer: On the b and man	e best of my ki asis of examin ner stated.	nowledge, deat nation and/or in	vestigation,	in my op	inion, deat	d place, a h occurre	d at the time, dat	e and place, a	and due to	the cause(s)
<b>1</b> 2		29b. Signature and title of certifier	who	lep	6		. License	D005	6428		d. Date signed April		
		30. Name and address of person w Humera Malik,	M.D.	10810	Connect		Ave.,	Kens	singt	on, MD	20895		
Stat Registra		31. Date filed (Month, Day, Year) APR 29		agistrar's Sign		do	and a	A.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kristian G. Koncke 04 - 2819Unpend Item #23a, 57, 50af Maryland (S) epayaryent of Health and Mental Hygiene 1 - For State Registrar AKG Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Kristian George Koncke 25, 7:30 A April 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Assateaque Island National Seashbre Assateaque Island Worcester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 213-35-5114 July 16, 1978 Uruguay Usual Residence of Decedent death with the Maryland Show 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or Items 23e or 28e-f shov treumatic event. Its Mudical Examinator must be multiled at 1 ☐ Yes 2 No Director Maryland Montgomery Damascus 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10202 Crosscut Way 20872 IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 21X Married Specify: White Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Uruguayan þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) 4 Art Director Web Design 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filt ment of Health and Mental Health and Mental Hent: If item 27 is marked officiny or other treumatic even Jorge Allan Koncke <u>Estella E. Fernandez</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katarzyna Anna Koncke/ Wife 10202 Crosscut Way, Damascus, MD 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 TCremation 3 ☐ Removal from State injury or April 27, permit. Page Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2004 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Auchard I Hales 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hallucinogenic Tryptamine Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit death certificate be executed Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

120 Yes 2 \( \subseteq \) No 24a. Was an page 2 Ves 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 □ No Other: 2 4 Nursing Home 5 Residence 6x50ther (Specify) At scene this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending Found 6:30 1 Natural 5 Pending after death. 1 Tes XX No Unknown investigation 2 Accident  $\mathbf{a}$ Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel o within 24 hours aft To the Funerel Di Found on island Assateague Island 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 16 Kroden ns O.C.M.E. April 26, 2004 11. use of death (Item 23a) (Type, Print) 30. Name and address of person who complete THEODIRE MIKIN 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)
APR 2 8 2004 32. Begistrar's Signature State appeare Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Unpend Item #23a&27 per me G831 5/13/04 tas Certificate of Death David P. Kuntz 15266 04 - 2852AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** David P. 1:34 P M Kuntz April 26, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's 11200 Evans Trail #202 Beltsville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer Oct. 9, 1971 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Months Yrs. 32 191-54-5117 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Beltsville Director Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20705 11200 Evans Trail, Apr.#202 United States Itеms 23a Completed by Funeral should be filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Affiled Folces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☐XNo Specify: White 3 Widowed 4 Divorced "natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Chef Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Is marked of Paul L. Kuntz Shirley A. Leibensperger ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health Paul L. Kuntz-Father 2380 Lower Smith Gap Rd. Kunkletown, PA 18058 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Metropolitan Crematory 4/29/2004 Alexandria, Virginia 0 = Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Fatty Liver disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 physician Physician/Medlcal the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Minknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1124 Yes 2 \( \subseteq \) No 24a. Was an page 2 s has autopsy performed? 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1**∑X**es 2 ☐ No this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 X Natural efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide filled in within 24 hours e To Ihe Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Diffeoil Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

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APR 30 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

April 27, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer **Physician** 6:55 PM 2004 ha /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 33-W; Dorchester ambridge 1 Year | 11 Under 24 Hrs. Street 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Hours 1 □ M 200 F Days Yrs. Director 12,1961 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County th and Mental Hygiene. 7 is markad other than "natural", or Items 23a or 28a-1 show traumatic event, the Medical Examinat must be notified at 1 De Yes 2 No Director ambrida 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 161 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Specify ģ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker 12 Manufacturino 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Health and Mental ementine ည JOHN Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place)

Date

Date

20c. Location - City or Town, State permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trau Necole Kane 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Malone Cenetery Madison. 4 ☐ Donation 5 ☐ Other (Specify) 04 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

12. He way fix we kall thome, P. A.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest,

Immediate Cause (Final) MD.216 Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ŏ Month Day Year 5 Other (specify) signed by the a o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by þe 3 Probably 4 Unknown 1 Tyes 2 200 peeu 24a. Was an autopsy performed? 1 ☐ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ♣ No has page 2 certificate of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Fesidence 6 Other (Specify) No 1 🗀 Inpatient 2 ER/Outpatient 3 DOA 2 1 🗌 Yes this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral to 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Injury To the Hospital or Attending 5 Pending investigation 1 Datural 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 😷 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance stated. Medical 29c. License number 29d. Date signed (Mpnth, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date liled (MonA PR

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			For State Registrar		State of M	arylan	d / Depa <i>Cei</i>	urtment of F tificate of	lealth and l Death		jiene <sub>eg. No</sub> .20	04	15268
			1. Decedent's Name	(First, Middle, Las	1)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Helen	Cl	narlene		KN	OX		April	24, 2		4:15 P M
	Examin	er	4a. Facility Name (If	not institution, give	street and number)				r Location of Death	1	4c. Count	y of Oeath	
					morial Ho		a1 last birthday)	O: If Under 1 Year	akland If Under 24 Hrs.	8. Date of Birth		Garr	
	Funeral Director		5. Social Security No. 212-60-0	11	M 2⊠F /.A.	72	Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	1	lace (State or Foreign try)
			Usual Residence of			12				Mar. 26	1932	Mary	land
	how		10a. State	10b. County		10c. City	, Town or Lo	cation				1	Od. tnside City Limits
	Be-fs	cto	MD		rett			Oaklar	nd				1 ☐ Yes 2X No
	or 24	Dire	10e. Street and Num					10f. Zip Code		1	0g. Citizen of	What Coun	try?
	s 23s	ral	215 N. 1	2th St.	40 May Danadana	Francia II	C 10.1	Nan Danadani at I	21550		14 Pa	USA ce - Americ	on Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumatic svent, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Marrid 3 অWidowed	ed 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Yas Decedent of Fif Yes, specify Cubi	dispanic Origin? (S) an, Mexican, Puerto Specify:	o Rican, etc.)		ick, White,	
21215-0036	2 hou	ted	<i>(</i> 2	15. Decedent's Ed			16a. Deced	lent's Usual Occup	ation	4.1-	16b. Kind of E	Business/Inc	iustry
215	thin 7 en "n Med	ple	Elementary/Secon	ify only highest grad ndary (0-12)	College (1-4or	5+)	life. L	NOT use retire	during most of wor d)	king			
7	ed wil	Con	12th					Housew				Hom <b>e</b>	
ב	be fill d off	Be	17. Father's Name (		1	T7.3				ne (First, Middle, i		_	
Maryland	d Mer narke	2	LeMoyne	me/Relationship (7	iul	K <b>1</b> 1		- Address /Ctreat	Nellie and Number or Ru	Agne		Stey	
<u>ā</u>	d 2 st th and 17 Is r treur						1	•		2 727 8	200000		C00e)
စ်	Heal Heal tem 2	1	20a. Method of Disp	Knox/dau	ignter	20b. P	lace of Dispo	N. 12th S		land, Mc Date	20c. Location		wn, State
Baltimore,	Pages ent of ht: If i			☐ Cremation 3 ☐: 5 ☐ Other (Specify	Removal from State		-	natory or other place	· •	7./0/	0.11	1 1	4
텵	mit. F partm. oorter injur		21. Signatore of Fu			Gari		Name and Addre		7/04 tewart F			aryland
m	Deg Time		M2c	soller H.	Dem		3:	2 S. Seco	ond St.,				
	Physician		Immediate Cause ( disease or condition	Final	lications that cause one cause on each l								Approximate Intervat Between Onset and Death Weeks
	/Medical Examiner		resulting in death)	•	Due to (or as	a consequ	ence of):						
	LAGIIIIIOI	_	Sequentially list con	nditions,	b. Due to (or as	2 000000	ience of						
	ted nsit	nine	Cause (Disease or	rlying	200 (0 g) (0		Sorring Org.						
<u>,</u>	icate be executed physician and s the buriat-transit	Examiner	that initiated events resulting in death) L	ast	c. Due to (or as	a consequ	uence of):						
68760,	le be rsicia e bur	edical			d								
_			i.e.ee										
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/M	tF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 № 9 ☐ Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			1	ate of delive onth	ry Day Year
	s that ned b e deta	by Pt	Part II. Other signifi	cant conditions co	ntributing to death b	out not resu	ulting in the ur	iderlying cause giv	en in Part I.	23e. Did tob	pacco use con	tribute to th	e cause of death?
ğ	w require been sig should b							_		1 □ Y€	s 2 XINo	3 🗌 Proba	ably 4 Unknown
Division of Vital Records,	The law requate has been page 2 should	Completed								24a. Was a autops perform	y ned?	Were autop prior to con death? 1 \( \sum \text{Yes} \)	osy findings available inpletion of cause of
/ita	icien: Th certificate rector, pag	Be	25. Was case referr		11			1.5		th (Check only on		-	
<del>_</del>	Physic this c	٩	1 ☐ Yes 2 ☒	40	Hospital:		ER/Outpatien		4 🗀 Nursing H	ome 5 Reside			)
u C	ding F h. After funera	lon:	27. Manner of Death  1 X Natural	5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Injur Wor M 1 🗆	y at k? Yes 2 □ No	28d. Describe ho	w injury occur	red	
S	l or Attenc after death Director: I in by the	ficat	2 Accident 3 Suicide	investigation 6 Could not be determined	28e. Place of In	iury - At ho	me, farm, stre	eet, factory, office	103 2 10	28f. Location (St	reet and Numl	ber or Rurai	Route Number.
<u>S</u>	after after Dire	Certification:	4  Homicide	Deuliumen	building, e	c. (Specify	")			City or Town	, State)		
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)		rsicien: To the best iner: On the basis of and manner st	of examinat							
	To th withir To th comp	Me	29b. Signature and	title of certifier	(0)		1	29c. Licens	e number	2	9d. Date signe	ed (Month, L	Day, Year)
			M	must	much	~ >	زجد	Н2	6154		4/2.	5/2004	4
				el Miller					Oakland	, Md. 215	550		
	Sta Registr		31. Date filed (Mont	APR 2 8	32. Registi	rar's Signat	ture	Cartin					

Maxine Leaman

4/24/04-1157/Am.

			Please	Type or Print in	n Black In	delible Ink	. Ensure Al	Copies	Are Legib	le.
			For State Registrar	State of Mary	land / Depa	artment of F	lealth and M Death	F	Reg. No.	10210
	Physici /Medi		Decedent's Name (First, Middle, Las	MAXINE E	. LEAMA	N		2. Date of Dea Month APRIL	_	3. Time of Death 11:57A M
}	Examir		4a. Facility Name (If not institution, give LONG VIEW NURS]		,	4b. City, Town, o	r Location of Death		4c. County of CARR(	
	Funeral Director		Social Security Number 6. S	7. Age (In	yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt! (Month, Day 7 / 3 / 1 9	n, Year)	D. Birthplace (State or Foreign Country) IRGINIA
	Maryland	tor	Usual Residence of Decedent           10a. State         10b. County           MD •         CARROL		City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 3a or 28e st be not	al Director	10e. Street and Number 2823 CARLISLE	DR.		10f. Zip Code 2177	6		10g. Citizen of Wh	at Country?
036	within 72 hours after death with the Maryland iene. r than "naturel", or items 23a or 28e-1 show tree Medical Evaninar must be routled at the Medical Evaninar must be routled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No ff Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. WHITE
5-0	72 ho natur	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of working	ng	16b. Kind of Busin	ness/Industry
21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired HOUSEW			HOME MA	AKER
Maryland 2	ild be filed lental Hygi rked other ilc event, II	To Be C	17. Father's Name (First, Middle, Last)	JOHNSON SI	NYDER E	ATON	18. Mother's Name MAUDE		Maiden Sumame)	r
lary	s 1 and 2 should f Health and Mer item 27 is marke other treumatic	_	19a. Informant's Name/Relationship (7				and Number or Rura			
	s 1 and f Health item 27 other tr		DIANA L. STULL  20a. Method of Disposition	-DAUGHTEI	R 314 b. Place of Dispo		AVE.,WES		PER, MD.	
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ot once.		1  Burial 2  □ Cremation 3  □ '4  □ Donation 5  □ Other (Specify	Removal from State	cemetery, crem DRT LIN	natory or other plac COLN CE	M. 4/28	/04 F	BRENTWOO	DD, MD.
Bai	permit Depar Impor eny in		21. Signature of Funeraf Service Licens	See H			ss of Facility FLE			
	Physician /Medical Examiner	ıer	23a. Part 1. Enter the disease, or ome shock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	nsequence of):	er the mode of dyin	ig, such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
. 68760,	leath certificate be executed attending physician and I for use as the burial-transit	Medicai Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cor	rsequence of):					
.O. Box	0 0 0	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		· <del>·····</del>	23d. Date of Month	
Δ.	The law requires that the site has been signed by the bage 2 should be detached.	þ	Part II. Other significant conditions co	ntributing to death but not	t resulting in the ur	nderlying cause giv	en in Part I.			ite to the cause of death?  Probably 4 Unknown
Records,	The law re ate has been page 2 sho	Completed			<u>-</u>			24a. Was a autops perform	med? prio	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vital	icien: ] certifical ector, p	Be	25. Was case referred to medical examiner?				26. Place of Death			
of	iding Physicien: th. : After this certifica i funeral director, p	- T	1 Yes 2 No	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien		4 Nursing Hon		ence 6 Other (	Specify)
Division of	or Attention that dear of the	Certification;	1	28e. Place of Injury - Abuilding, etc. (Sp	At home, farm, stre		Yes 2 □No		treet and Number of	or Rural Route Number,
	To the Hospitel or Attention within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Offitifying Phy 2 Medical Exam	rsician: To the best of my iner: On the basis of exar and manner stated.	knowledge, death mination and/or inv	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cad at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
•	To the To the comp	Σ	29b. Signature and title of certifier				36712 8	10	9d. Date signed (A	fonth, Day, Year)
	ply		30. Name and address of person who co	A ((			te 4 on	pster?	m2 2	(0)4
	Sta Regist	_	31. Date filed (Month, Day, Year) APR 2 7 2	32. Redistrar's S		Sacreti )		1		

State o

of Maryland / Department of Health and Mental	Hygiene 2004	15272
Certificate of Death	Reg. No.	10616

		•	1 - State Registrar			Ce	rtificate d	of Dear	th		Reg. No.	- 00 g	13616
			1. Decedent's Name (First, Middle, Last)						1	2. Date of De		Year	3. Time of Death
	Physici /Medic		GEOR	GE H.	LAV	<b>JLER</b>				APRIL	21,	2004	5:00 A M
No.	Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Tow	n, or Location	on of Death		4c. (	County of Death	
			HOLY CROSS REHAB.	& NURSIN	G CI	ENTER			VILLE		1	ONTGOM	ERY
A.	Funeral Director		423-30-6011	M 2□F 7. Age	66	/ast birthday) Yrs.	If Under 1 Ye Months Da		s Min.	B. Date of Birt (Month, Da SEPT.	y, Year)	9. Birth <i>Cou</i>	place (State or Foreign intry) ABAMA
	yland how		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
	e Ma	cto	NC CUMBERLA	ND			FAYETT	EVILL	E				Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Cod	0			10g. Citiz	en of What Cou	intry?
	ath w		1717A SHAW RD					2831				U.S.A.	
036	d within 72 hours after death with the Maryland piene. I then "natural", or items 23a or 28a-f ehow The Medical Evanimer must be notified at	by Funeral	11. Marital Status  1 Never Mamed 2 Married  3 Widowed 4 Divorced	2. Was Decedent I Armed Forces? 1X Yes 2 ☐ N If Yes, Give Year or Dates:		2-	Was Decedent If Yes, specify C 1 ☐ Yes 21 ☐			ify Yes or No- ican, etc.)		4. Race - Ameri Black, White Specify: BI	
9500-51212	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Educ (Specify only highest grade	completed)		(Give	dent's Usual Oc kind of work do DO NOT use re	ne durina n	nost of working	9	16b. Kin	d of Business/Ir	ndustry
	ed withi giene. er then	Comp	Elementary/Secondary (0-12)	College (1-4or 5	+)		MACHIN				KELI	Y SPRIM	GFIELD CO.
land	be filed tal Hygi d other	Be (	17. Father's Name (First, Middle, Last)					18. Mo	other's Name (	First, Middle,	Maiden S	Sumame)	
<u>∑</u>	should by nd Menta i marked umatic av	은	NELSON	LAWLE	R				EUL			YLOR	
Mary	2 2 2 2		19a. Informant's Name/Relationship (Typ									Town, State, Zi	
_	1 and leaith em 27 ther ti		PAMELA LAWLER/DA  20a. Method of Disposition	AUGHTEK	20h. l	3409	RUBLY sition (Name of		• #304 Da			KING, Nation - City or T	D. 20904
altimore,	Page ment: H ant: H		1 Burial 2X Cremation 3 Re 4 Donation 5 Other (Specify)	amoval from State		cemetery, crei	S CREMA	place)	1			ERDALE,	
Rail	permit. Departr Imports any inji		21. Signature of Funeral Service Liberse	nlessed	Moo		Name and Ad HAMBERS 801 CLE			ME & CI	REMAT RDALE	ORIUM, F	2.0 <b>A</b> 3.7
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused a cause on each lin	the dear								Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition	PNEUMON	IA								Onset and Death
	/Medical		resulting in death)	Due to (or as	a consec	quence of):							
	Examiner		Sequentially list conditions, b	LUNG CA									
	ed sit	line	cause. Enter Underlying Cause (Disease or injury	Die to (or se	a consec	plianes of):							
	te be executed ysician and te burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consec	uence of):							
2	be e sician buria			,									
09/89	ficate phys s the	Medical	d										
×	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant 23	lc. If yes, outcome							23	d. Date of deliv	erv
20	death e atte d for	by Physiclan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregna Other (specify)					Month	Day Year
j.	t the by the	hys	9 Unknown	9□ Unknown									
ν, L	res tha igned be del	y P	Part II. Other significant conditions con	ributing to death bu	at not res	sulting in the u	nderlying cause	given in Pa	at I.	23e. Did to	bacco us	e contribute to t	he cause of death?
ğ	w require been sig should b	ed	DIABETES MELLI	<u>rus</u>						1 🗆 Y	/es 2□	No 3 ☐ Prol	babiy 4XIUnknown
Hecords	sician: The law requi certificate has been irector, page 2 shoul	Completed								24a. Was autop		death?	opsy findings available impletion of cause of
ta	an: T	0	25. Was case referred to medical					26 PI	ace of Death (			1 🗆 Yes	2∐ No
	Physician: this certific ral director,	0 8	examiner? 1 Tes 2 XNo	ospital:	nt 2	ER/Outpatien	t 3 DOA	0.0				□Other (Specia	(v)
lo n	De le	n: T	27. Manner of Death  1X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury		njury at Vork?		d. Describe h			,,
0	Attending r death. ector: After by the fune	catic	2 Accident investigation					Yes 2	□No				
UIVISION	i te	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ıry - At h :. <i>(Speci</i> i	ome, farm, str fy)	et, factory, offi	ce	28	If. Location (S City or Tow	Street and m, State)	Number or Rura	al Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	icien: To the best of er: On the basis of and manner sta	examina	owledge, death ation and/or in	occurred at the vestigation, in m	time, date y opinion, d	and place, an leath occurred	d due to the o	cause(s) a date and p	nd manner as s place, and due to	stated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	()			29c. Lice	ense numbe	er .		29d. Date	signed (Month,	Day, Year)
•	(ch.							D0058	962		APR	IL 21,	2004
	(-1.		30. Name and address of person who con	npleted cause of de	eath (Iter	m 23a) (Type,		20000	JUL		TI V	LU 219	2004

State Registrar

31. Date filed (Month, Day, Year) APR 2 6 2004

SHASHANK G.

SHOREFIELD RD., WHEATON, MD. 20902 2309 PATEL, M.D. 32. Registrar's Signature parker

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 6:00 P M APRIL LEW 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 100-14-2923 81 11/20/1922 POLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show 1 ☑ Yes 2 ☐ No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 MONTROSE ROAD #3119 20852 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced WHITE "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Ma College (1-4or 5+) Elementary/Secondary (0-12) 12 OWNER FURNITURE MANUFACTURER 27 is marked other traumatic event, il 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be JOSEPH LEW ROSA BECKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other training. LINDA WEINSTEIN/DAUGHTER 13511 CEDAR CREEK LANE, SILVER SPRING, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MT. ARARAT CEMETERY 104/25/2004 LONG ISLAND, NEW YORK 21. Signature of Funeral Service Licensee e and Address of Facility
RD SAGEL FUNERAL DIRECTION,
ROCKVILLE PIKE, ROCKVILLE, INC. MARYLAND 20852 ĬŎ91 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician hemic 15 C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \( \text{\tiliex{\text{\texi}}\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\text{\texit{\texi}\text{\text{\texit{\tex{\text{\text{\text{\text{\texi}\text{\texit{\text{\texi}\text{\ 1 Yes 2 No 2 ctor: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier will 22528 3+1 mass. 30. Name and addrers of person who completed cause of death (Item 23a) (Type, Print) ROLLUTUE MARYLAND 20052 6121 MONTRESE NOAD WIKS, JARY mID 31. Date filed (Month, Day, Year) APR 2 7 32. Registrar's Signature State 2004 Registrar

			For Stete Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of He	ealth and M Death		ene2004	15274
			Decedent's Name (First, Middle, Last)		1 1	1		2. Date of Death		3. Time of Death
	Physicia /Medic		Jerry	4	obel	/		Month 04	Day Year	2:32 AM
1	Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
			14112 Laurel Avenue			Ocean (	City If Under 24 Hrs.	8. Date of Birth	Worceste	hplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1579-36-4055	7. Age ( <i>In yrs.</i> 7. Age 7. Age ( <i>In yrs.</i> 7. Age 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs</i>		Months Days	Hours Min.	Sept. 30	(ear) Co	untry)
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	rylan show		10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f s	Director	Maryland Worceste	r	UCE	ean City		10-	. Citizen of What Co	
	th with the 23a or 2		109. Street and Number 10900 Coastal Highw	ay #305		10f. Zip Code 2184	2		nited Sta	
336	n 72 hours after death with the Maryland "netural", or Items 23a or 28a-f show wited Examitizatious be multiled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	"	Vas Decedent of His Yes, specify Cuban	spanic Origin? (Sp. , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
9	n 72 hor "netura	ted	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	lent's Usual Occupa kind of work done di	tion uring most of work	ina 16	b. Kind of Business/	Industry
215	d within 7 jiene. r than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	nessman	g		Retail	
121			17. Father's Name (First, Middle, Last)	3	Dusii		18 Mother's Name	e (First, Middle, Ma		
Maryland 21215-0036	be d d	To Be		raham Lobel				l Shimon		
lary	and and sum		19a. Informant's Name/Relationship (Typ			•			City or Town, State, 2	
0	and lealth m 27	1	Amy Fadida, Daughte			Laurel Av			, MD 2184 oc. Location - City or	
õ	or off		20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ Re	emoval from State	emetery, cren	natory or other place	101,21	/ 04		
Baltimore,	permit. Pages to Department of Himportent: If ite eny injury or ot once.		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Singular of Fore of Sharper License		22	Memoria  Name and Address	s of Facility		alls Churc	cn, VA
Ba	Department Impo			<i>7.</i>	To	orchinsky	Hebrew F			2001.0
			23a. Parti-Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat	n. Do not enti	or the mode of dying	, such as cardiac	or respiratory arres	gton, UL	20012 proximate Interval Between
	Pnysician	W 1	Immediate Cause (Final disease or condition	Metas to	4.0	3/2200	- Can	-		Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq						1096.3
	Examiner		Sequentially list conditions, b							
	.ed	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence or):					
	be executed sician and burial-transit	Examin	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):					
8760,	cate be c physicial the buri	dicai	d							
9	tificat ng phy as th	Medi	IC FERMIS							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	res that igned b be deta		Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w require been sig should b	ed b						1 ☐ Yes	2 □No 3 Pr	obably 4 Unknown
of Vital Records,	The law requivate has been page 2 should	Completed by						24a. Was an autopsy performe	id?。   death?	topsy findings available completion of cause of
/ita	iding Physician: Th th. : After this certificate s funeral director, pag	Be	25. Was case referred to medical examiner?	- itali		0#5	26. Place of Deat	h (Check only one)	, Da	Jante-1
<b>J</b> o	Physic this c	2	T Tes 254NO		ER/Outpatien	the state of the s	The Assertance of the Control of the	me 5 Resident		residence
uc	Jing I	ion	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	Injury	Work		20d. Describe now	injury occurred	
Division	Attend death ctor: y the	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, str				et and Number or Ru	ral Route Number,
á	al or /	Certification;	4  Homicide	building, etc. (Specif	Y)		Į,	City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	ledical (		ician: To the best of my knower: On the basis of examina and manner stated.						
		¥	29b. Signature and title of certifier		n.o	29c. License			I. Date signed (Month	
1	12		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)	5 F C	arroll 57	5.1-	2004 21801 2007, MD
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture /	1			, 00100	,
	Regist		APR 2 7 2004	Green	Ø	Sporth				

		State Registrar  1. Decedent's Name (First, Middle, Lasi	State of Maryland /	Certificate of Death	Reg. 2. Date of Death	, No. 2004	3. Time of Deat
sicia edic imin	al .	ROLAND M. LLOYD,  4a. Facility Name (If not institution, give	, SR.	4b. City, Town, or Location of De		Day Year 22 2004  4c. County of Death	6:45PM
eral		MALLARD BAY CARS 5. Sociel Security Number 6. Se		CAMBRIDGE birthday)   If Under 1 Year   If Under 24 F  Wonths   Days   Hours   M	Irs. 8. Date of Birth (Month, Day, Y	DORCHES  9. Birth Cou 1917 MAR	STER place (State or Fore intry) EYLAND
	or	213-14-1178		own or Location  NEWCOMB	J30H1 13		10d. Inside City Lin
	i Director	10e. Street and Number 7398 BACK STREET	IDOT	10f. Zip Code 21653	10g	. Citizen of What Cou	intry?
the Medical Extra permanance nothing of	by Funeral	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 □ Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Amen Black, White, Specify: WF	
	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	b. Kind of Business/Ir	
radicionic evenit, in	To Be Co	7 17. Father's Name (First, Middle, Last) LAFAYETTE LANGRAJ	LL LLOYD		K. Name (First, Middle, Ma Y. CREIGHTON	CONSTRUCTI iden Sumame)	.UN
	-	19a. Informant's Name/Relationship (7 DIANE L. RICHARDS)	Type, Print)	9b. Mailing Address (Street and Number or 7598 BLUEBERRY ACRE			
	Compt	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify	Removal from State	of Disposition (Name of Itery, crematory or other place)		c. Location - City or T	
ODCO.		21. Signature of Funeral Service Licen	see	22. Name and Address of Facility FELLOWS, HELFENBE 200 S. HARRISON S	TN & NEWNAM	FINERAL F	
cal		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  a. Due to (or as a consequence)		diac or respiratory arrest		Approximate Interval Betwee Onset and Deat
	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence				
	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3 □Ectopic pregnancy		23d. Date of deliving Month	
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 04 04 2:58a M Blanche Mary Montgomery /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LaPlata

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. | Dec. 9, Charles Civista Medical Center 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2**]** F Months Days Yrs. 219-56-0328 73 1930 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant, the Medical Examiner must be mutified at 1 Yes 2 No **Funeral Director** Maryland Charles Nanjemov 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10810 Gethsemane Road 20662 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Contractor Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be William Warren Mary Carroll 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10810 Gethsemane Rd., Nanjemoy, Md. 20662 Joseph Montgomery Husband Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place)

May 4 2004

Maryland Veterans Cemetery 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages
Department of I
Important: If Ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licensee m **~**√ M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part1. Enter the sissase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ever **Physician** /Medical Due to (or as a conseduence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed Due to (or as a consequence of): burial-t Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 157 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D-21031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leatherwood, MD 12070 Old Line Center Waldorf, MD 20602 Michael Α. 31. Date filed (Month, Day, Year) 32. Registar's Signature State MAY 03 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

MAY 1 2 2004

			. For	State of Marylan	d / Depa	artment of H	lealth and N	Mental Hyg	iene	1. 15270
		_	. region as		Ce	rtificate of l	Death	2. Date of Deat		4 5278
	Physicia	_	1. Decedent's Name (First, Middle, Last) Ethel Estelle Mich	naal				Month May 1,	Day Year	7:30 P M
	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Dea	
	Examin	er	2160 Pineview Cour			Waldor	rf .		Char1	
ý,	Funeral Director		5. Social Security Number 6. Sex 577-32-8447	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr. 20	9. Bir (Co. 1926 Pen	thplace (State or Foreign buntry) INSVIVania
	g.		Usual Residence of Decedent		<del></del>	<u> </u>		, , , , , , , , , , , , , , , , , , ,	, 10201.011	10d. Inside City Limits
	show	'n	10a. State 10b. County		ty, Town or Lo					1 ☐ Yes 2 🂢 No
	28a-f	Director	Maryland Charles  10e. Street and Number		Waldor	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	th with 23a of 151 be	al Di	2160 Pineview Cour	rt		2	20601		USA	
	tems	Funeral	11. Wallar Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
036	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or items 23s or 28s-f show d other than "natural", or items 23s or 28s-f show event, the Madical Examinar mast be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
S S	72 ho 'natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Business	/Industry
121	within ene. than be we	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	Clerk	"		Postal Ser	rvice
מ	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, i	Maiden Sumame)	
<u>/lar</u>	should be filed ind Mental Hygis marked other urnatic event, I	To B	Oscar Melvin King					Miller Ba		
Zan	i 2 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type Warren C. Michael		1	ng Address (Street Pineview			, City or Town, State, 20601	Zip Code)
<u>6</u>	Healt Healt tam 2		20a. Method of Disposition		_	osition (Name of matory or other place			20c. Location - City or	Town, State
Ē	Pages nent of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ft	. Linc	oln Cemet	ery 5-5-0	04 I	Brentwood,	MD
Baltimore, Maryland 21215-0036	permit Pages 1 and 2 should by Department of Health and Menta important: If item 27 is marked any injury or other traumatic and any other traumatic and any other traumatic and any other traumatic and any other		21. Signature of Funeral Service License	<sup>9e</sup> M01391	2	2. Name and Addre Huntt Fun P. O. Box	ss of Facility eral Home 156. Wa	Idorf. MI	20604	
H	= ,0 -		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dea	th. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	END ST	Agi-	CHRON	ic Obs	structiu	DIJCAE	Oriset and Death
ß	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):		pulm	an Ary	DIJCASE	YRS
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):		<u> </u>	· · · · · · · · · · · · · · · · · · ·		
_	and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence ol):					
760,	ite be executed sysician and ne burial-transit	calE	l.	1.						
68	rifficate ng phy as the			4						-
Вох	that the death certificat ed by the attending phy detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1☐Live birth 2☐Fet 4☐Pregnant at time of	al death 3	☐Ectopic pregnancy ☐ Other (specify)	1		23d. Date of de Month	olivery Day Year
P.0.	the de y the a	nysic	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown	ueatti St	Other (specify)				_
ds, P.	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	by	Part II. Other significant conditions con	ntributing to death but not re-	sulting in the t	underfying cause giv	en in Part I.		bacco use contribute t es 2□No 3□P	rothe cause of death?
COL	w requ	letec						24a. Was a		utopsy findings available
Vital Records,	The lay	Completed						autop: perfor 1  Yes	med? death?	completion of cause of s 2□ No
/ita	cian: ertifica	Be	25. Was case referred to medical examiner?	lo apital:		- 20 DOA O#	000	ath (Check only or		-
of	ding Physician: The I h. After this certificate ha funeral director, page	7	1 ☐ Yes 2 XNo  27. Manner of Death	28a, Date of Injury	28b. Time of	of 28c. Injur	4 ∐ Nursing F		ence 6 Other (Spe ow injury occurred	ecify)
ion	Attending r death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1	rk?  Yes 2 □ No			
Division	l or Attendate after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, larm, si ify)	treet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director:	ledical C		sician: To the best of my kn ner: On the basis of examin and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
	. >= 0		1/40 du	AHEN	DIL	DL	1443.	6	MAY 3, 20	04
7	RI.		30. Name and address of person who co				אַר ואַנוּ פּר	DE MD 9	0602	
A		ate	ASHVIN J. PATEL, I	MD, 102 PAUL  32. Registrar's Sign	nature		Z, WALDU	NF, MU Z	UUUZ	
	Regist		MAY 0 4 2	2004	J.	Cook				

		1 - For State Registrar	State of Ma	ryland	-		nt of H				Reg. No	711	04	15279
Physicia		1. Decedent's Name (First, Middle, Last Samuel M. Maddox,								2. Date of D Month April	Day	, 2004 <sup>°</sup>	ear	3. Time of Death 2:55am M
/Medica Examine		4a. Facility Name (If not institution, give	street and number)	1			Town, or		of Death			County of		
Funeral Director		Shady Grove Advent 5. Social Security Number 6. Security Number			st birthday) Yrs.	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth (ay, Year)	9		lace (State or Foreign try)
P .	Director	Usual Residence of Decedent	ry		Town or Lo	y Vi	llage					izen of Wh		0d. Inside City Limits 1 ☐ Yes 2 ☑ No
urs after death v al', or Items 236	by Funeral	6 Mastenbrook Cour  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 X No If Yes, Give Year or Dates:			Was Dece f Yes, spe	20886	spanic Ori n, Mexicai		ecify Yes or N Rican, etc.)	Uni	ted S	tat	es an Indian, etc.
within 72 hound.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5-	-)		kind of w DO NOT i	ual Occupa ork done d use retired,	<i>luring</i> mos )	it of work	ing	16b. K	ind of Busin		dustry
should be filed vold Mental Hygie i marked other turatic event, to	To Be Co	17. Father's Name (First, Middle, Last)  Samuel M. Maddox.	,		rat	LICIIIA	LICIA	18. Moth		в (First, Middi				
and 2 shot ealth and N m 27 is mai		19a. Informant's Name/Relationship (T Jessie S. Maddox			6 Ma	sten	brook	Cou	rt, I	al Route Num Montgor Date	nery		ge,	MD 20886
permit. Pages 1- Department of He mportent: If iten any injury or un		20a. Method of Disposition  1	)	1	ace of Dispo metery, cren coln N	1emor	ial (	Cem.	4/2	29/2004 Yol Fui	Su:	itlano	1. M	laryland
permit. Departinimporte any inju		23a. Part1. Inter the dise sec, or compshock, inheart failure. List only of	DWH	the death.	I G	O Ea: aith	st De ersbu	er Pa	ark . MD 2	0rive 0877		27032	Ti	Approximate Interval Between
Physician   Physician   Physician   Physician   Physician and   Physician and   Physician	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Prostate Due to (or as a b. Renal Found to (or as a c. Due to (or as a	e Can conseque ailur	ncer ence of): re ence of):									Onset and Death 1 Year 6 Months
death certificate e attending phys d for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	d	2 🗌 Fetal (	death 3	Ectopic	oregnancy specify)					23d. Date (		ory Day Year
w requires that the been signed by the should be detached.	ģ	Part II. Other significant conditions of	ontributing to death bu	t not resul	lting in the u	nderlying	cause give	en in Part	l.		tobacco Yes 2			ne cause of death?
The law ate has b page 2 st	Completed									per 1 ☐ Yes	opsy formed? 2 🛛 No	prid	or to cou	psy findings available impletion of cause of 2 No
Phys rat dii	ion: To Be	25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day		ER/Outpatier 28b. Time o Injury		28c. Injun Worl	er: 4 □ N	ursing H	th <i>(Check onl)</i> ome 5 Re 28d. Describ	sidence			y)
To the Hospitel or Attending within 24 hours after death of TO the Eunerel Director. After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		iry - At hor :. (Specify)	me, farm, sti						(Street ar own, State		or Rura	l Route Number,
he Hospi n 24 hour he Funer bletely fill	Medical		ysician: To the best of niner: On the basis of and manner sta	examinati		vestigatio	n, in my o	oinion, de			e, date an	d place, an	d due to	the cause(s)
To the within To the To the Comp	W	29b. Signature and title of certifier	ambo	ab Or	20-1-7		DO (		08	3		te signed (		Day, Year)
Sta Registr		30. Name and address of person who Paul M. thambi, M 31. Date filed (Month, Day, Year)	D 9707 Me 32. Begistra	dical	l Cent	er D	rive		Roc	kville	, MD	20850	)	

			1 - For State Registrar	State of Maryla		artment of F			21	004	15280
	- A		Registrar     Decedent's Name (First, Middle, Last)			Timoato or	Douin	2. Date of De	Reg. No. C.		3. Time of Death
	Physici /Medic	al	Eugene  4a. Fecility Name (If not institution, give s	F. Maho	lchic	4h City Town	or Location of Deat	Month April	Day	Year 004	11:35 A <sup>M</sup>
	Examir	er						11			
	Funeral Director		Montgomery General 5. Social Security Number 6. Sex 179–16–3978		s. last birthday) Yrs.	Olney If Under 1 Year Months Days		(Month, Da			y ce (State or Foreign ) ylvania
	pu 🗼		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	ocation				104	Inside City Limits
	anyla shon	5			-					100	1 X Yes 2 No
	28a-f	Directo	Maryland Montgome  10e. Street and Number	ry	Rockvil	10f. Zip Code			10g. Citizen of V	Mhat Causta	
	with a or		14208 Chelmsford	Pond		2085	3		United	•	
	eath	erai		2. Was Decedent Ever in	U.S. 13.			pecify Yes or No		e - American	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Modical Exemplear must be routlied at	y Funerai	1 ☐ Never Married 2 ※ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 [X]Yes 2 ☐ No If Yes, Give	1943-	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2X No		o Rican, etc.)	Blac Specify	ck, White, etc	).
Ş	hour	ed t	15. Decedent's Educ		1946	dent's Usual Occup	nation		16b. Kind of Bu		
21215-0036	in 72 n " n	Completed by	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most of wo	rking	TOD. THING OF DO	2011100001111000	,,
7	l with iene. r ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Cont	ract Admi	nistrato	r	U.S. G	overnm	ent
0		BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	, Maiden Surnam	10)	
au	Mental Merked o	To B	George Maholchic				Clair	e Wasley	7		
Maryland	and and sm	_	19a. Informant's Name/Relationship (Type Irene Maholchic			ng Address (Street 8 Chelmsf					
	1 and 2 Health tem 27	17	20a, Method of Disposition			osition (Name of matory or other place		Date	20c. Location -		
Baltimore,	Pages nent of int: If it		1 🕅 Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	BINOVALITORI STATE			- Thi	cil 26,			
₹	artme ortan injur		21. Signature Funeral Service License			leaven Cer 2. Name and Addre		1	Silver S		, m <i>D</i>
g	permit. Page Department of Important: If eny injury or once.	IJ	I Luxle 1	11		East De	D	eVol Fur			20077
	ę.		23a. Part1. Enter the disease, or complic	cations that caused the de						A	pproximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final	_						0	terval Between nset and Death Days
A. W.	/Medical	2	disease or condition resulting in death)	Pneumonia  Due to (or as a cons	equence of):		<u> </u>			4	Days
	Examiner		Sequentially list conditions	Delmonore		th Partia	al Bronch	nial Obs	truction	n 1:	l Months
50		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons							
	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events								
o,	a exe		resulting in death) Last	Due to (or as a cons	equence of):						
3760,	ate be nysici he bu	ical	<b>€</b> d								
89		Physician/Med	IF FEMALE:								
Rox	eath certific attending pl for use as t	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1□Live birth 2□Fe		Ectopic pregnancy	/		23d. Dat Moi	te of delivery nth Da	y Year
	at the dea by the al tached fo	sici	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	f death 5	Other (specify)			IVIOI	iiiii Da	iy real
Р. О	d by letach	Phy	Part II. Other significant conditions conf	terbusines to death but and	anultina in the co	_ 4 _ 4 . /	i- D1	22a Did to		albuda da dha a	anusc of death?
Š	The law requires that the tee bas been signed by the bage 2 should be detached.	by	Type II Diabete		esulung ar the u	ndenying cause giv	en in Pan I.	T	obacco use conti Yes 2∑No		y 4 Dünknown
50	w require been signations	ted	Type II Diabete	5 HEIIICUS					165 243110		y 4 GOIRIOWII
ec	a law	Completed	Vasculitis					24a. Was autop	osv c	prior to compl	findings available etion of cause of
I		Con	Prostate Cancer					perfo		death? □ Yes 2□	☐ No
Vital Records,	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?			100		ath (Check only o	ne)		
10	hysi this c	မှ	1 105 2 NO	ospital: 1X Inpatient 2			4 🗆 indising i	lome 5 Resid			
_	ing P	on:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor	k?	28d. Describe h	now injury occurr	ed	
<u>s</u>	Attending ir death. ector; After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division	or Al	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe		eet, factory, office		City or Tox	Street and Numbe vn, State)	er or Hural Ho	oute Number,
_	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier 1X Certifying Phys	ician: To the best of my k	nowledge de l'	h accurred at the co	no data and all	and due to the	201100/-> - :		Adventa in -
	24 hc 24 hc Fun etely	edical	(Check only 2 Medical Examin	er: On the basis of exami and manner stated.	nation and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place, a	nner as state and due to the	d. e cause(s)
	To the within 2 To the complet	Me	29b. Signature and tille of certifier		<b>—</b>	29c. Licens	e number		29d. Date signed	(Month, Day	r, Year)
	1 11		· VYKI	ul		рз	5045		۸ • ٦	22 22	0.4
	611		30. Name and addr ss of person who cor	mpleted cause of death (III	em 23a) (Type		JU-1J		April	ZZ <b>,</b> 20	U4
			Philip G. Henjum, N				#204. O1	nev. Mar	cyland 2	0832	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature /				<i>y</i> = 3a 2		
	Registr		APR 2 7 200	4 Seneva		sparks					

		,	For State Registrar		State	f Mary		epartm Certific				Mental Hy	giene Reg. No. 2	004	15%	281
	Physicia	an	1. Decedent's Nam									2. Date of D Month Apr:		2004r	3. Time of	
	/Medic	al	Corinne					4b. 4	Sity Town o	or Locat	ion of Deatl			ZUU4	8:20	РМ
	Examin	er	4a. Facility Name (I			(HD <del>O</del> I)			thesd			11		tgome		
	Funeral		5. Social Security N		. Sex	7. Age (In	yrs. last birth		nder 1 Year	If Ur	nder 24 Hrs.	8. Date of B	rth Year) 26		place (State o	
- 1	Director		579-28-9		1 □ M 2 🛣 F	77	7 Y	rs.	ths Days	Hot	JIS IVIII.	Sept.	2°, °1926	Wasi	ingto	n, DC
	and w		Usual Residence of 10a. State	10b. County		10	c. City, Town	or Location							10d. Inside Ci	ity Limits
	Many I sho	to	MD	Montg	gomery	F	Betheso	la							1 🗌 Yes	2 💢 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Importent: If Item 27 is marked other then "natural", or Items 23s or 28e-f show any injury or other treumatic event, the Modical Examination at pages.	Funeral Director	10e. Street and Nu 5837 Mar		ıd			101	Zip Code 2081	7			10g. Citizen o		ntry?	
	r deat	Iner	11. Marital Status		12. Was Dec Armed F	orces?	r in U.S.	13. Was D If Yes,	ecedent of I specify Cub	Hispanio an, Mex	o Origin? (S xican, Puerl	specify Yes or N to Rican, etc.)	o- 14. F	ace - Ameri lack White White		
36	rs afte	<b>by</b> Fu	1 Never Marr	ied 2 Marrie 4 □ Divorced	d 1 ☐ Yes If Yes, G Year or [	ve		1 🗆 Y	s 2 🔀 No	Spe	cify:		Spe		ce	
21215-0036	2 hour	ted t		15. Decedent's	Education		16a. I	Decedent's	Jsual Occup	pation			16b. Kind of	Business/Ir	ndustry	
215	hin 72 9. 9n "na	Completed	(Spec		grade completed) College (	1-4or 5+)	1			during ad)	most of wor	rking				
2	ed wil	Con			4		Ho	nemake	er	40.14	1-15-d- bl-	(5) 14:11	Own H			
pue	Ibe fil ntal H ed oth	Be	17. Father's Name Christi									ne <i>(First, Middl</i> e 10 Youn		ame)		
Maryland	thould nd Mer mark matic	2	19a. Informant's N				19b.	Mailing Add	ress (Street		_	ıral Route Numi		m, State, Zi	code)	
Ma	nd 2 salth ar 27 is r treu				husban	d	58:	37 Ma	bury	Rd.	Beth	esda, M	D 20817			
ore,	es 1 a of Hea f Item r othe		20a. Method of Dis		B □Removal from	State 2	20b. Place of cemetery	Disposition , crematory	(Name of or other pla	ice)		Date	20c. Locatio	n - City or T	own, State	
, ŭ	Pag Iment Iury		` 4 ☐Donation	5 □ Other (Spe	ecify)		Rock Cr					3, 2004				
Baltimore,	permit Depart Import any in		21. Signature	maral Service L	A/Ca	· C		22. Nam 5130	e and Addre	ess of F	<sup>acility</sup> Jo n Ave	seph Ga • NW Wa	wler's shingto	Sons, n, DC	Inc. 20016	
	Physician		25a. Part1. Enter the shock, or head immediate Cause disease or condition resulting in death)	art failure. List of (Final	omplications that nly one cause	caused the each line.	death. Do n	ot enter the	mode of dyi		urE		arrest,		Approximate Interval Bett Onset and I	e ween Death
8760,	that the death certificate be executed with the attending physician and detached for use as the burial-transit	dicai Examiner	Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease or that initiated event resulting in death)	onditions, nmediate arlying injury s Last	c	(or as a co	onsequence o	i):	NIC	OB	stri	LCTIV	EAIRI	VMS.	OLSEAS.	Ċ.
P.O. Box 68760	the death certificated the attending phyched for use as the	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	! months? ☑No		birth 2 🗀 nant at time	Fetal death		ic pregnanc r (specify) _	у				Date of deliv	-	Year
	uires that the de signed by the a Id be delached f	by	Part II. Other signi	ficant condition	s contributing to	leath but no		the underly		ven in P	Part I.		tobacco use co Yes 2 □ No		le le	death?
۲ Records,	sicien: The law requires seartificate hes been sign lirector, page 2 should be	Completed	CRITIC	CAL 11	LNES	5							opsy ormed?	prior to co death?	opsy findings empletion of c	available ause of
	nn: Ti ifficate or, pa	e Co	25. Was case refe	rred to medical						26 F	Place of Dea	1 ☐ Yes ath (Check only	201No	1 🗌 Yes	2 L No	
Pm f Vit	Physicien: this certific ral director,	O B	examiner?	Mo	Hospital:	Inpatient	2 ER/Out	patient 3	DOA Ott	her		dome 5 ☐ Res		ther (Speci	fy)	
. TO 0	ding Phys n. After this funeral di	n: T	27. Manner of Dea	th 5 Pending	28a. Date (Moi	of Injury oth, Day Ye	28b. Ti	me of jury	28c. Inju Wo	ry at		28d. Describe	how injury occ	urred		
220 Pm	Attending r death. sctor: After	catic	2 Accident	investiga	ition			М	-	] Yes	2 🗌 No					
S 42 Division	s after d s after d al Direct	Certification:	3 Suicide 4 Homicide	determin	289. Plac	e of Injury - ling, etc. (S	- At home, far Specify)	m, street, fa	ctory, office				(Street and Nui own, State)	mber or Rur	al Route Num	ber,
Martin, 4/26 Divi	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one)		Physicien: To the xaminer: On the and man		amination and									;)
	To the To the To the Complex C	Σ	29b. Signature and	ville of codifie	1				29c. Licen:	se numi	ber	\_1	29d. Date sign	ned (Month,	Day, Year)	
	20			11 0	vyus				<u>D</u>	4	15-	71	TIZ	7/0	14	
	(2)		30. Name and add	1	no completed cau ID 10215				hesda	, MI	2081	.7				
	Sta	ate	31. Date filed (Mor	nth, Day, Year)		Registrar's	Signature	4	bank							
	Regist			APR 2.8	2004	ener	6	1 /	ware.	4.0						

**ORIGINAL** 

			For State Registrar		State of M	1arylan		artment of H		ınd M		jiene <sub>leg. No.</sub> 2	004	152	283
	Physici		1. Decedent's Name (First, Robert The		Mason						2. Date of Dea Month April	Day	2004	3. Time of 5 : 15	Death A <sub>M</sub>
	/Medio Examin		4a. Facility Name (If not ins			r)		4b. City, Town, or	Location o	f Death	TIP I I I		unty of Deat		
	xaiiiii		12609 Steep	ole Cha	ase Way			Potoma	ıc			Mo	ntgom	ery	
	Funeral Director		5. Social Security Number 067–26–5294		7. A	Age (In yrs. 67	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min	8. Date of Birth (Month, Day Jan. 29	Year)	Co	nplace (State o untry) York	r Foreign
	and w		Usual Residence of Deceder 10a. State 10b. C			10c. City	y, Town or Lo	cation						10d. Inside Ci	ty Limits
	Mary!	tor	Maryland Mon	ntgome	rv	Po	otomac							1 🗌 Yes	2 <u>K</u> No
	h the	lrec	10e. Street and Number					10f. Zip Code			1	l 0g. Citizer	of What Co	untry?	
	23a c	alD	12609 Stee	ple Ch	ase Way			20854					JSA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-1 show miniour or other treumetic event, It is Midical Examinator must be inclified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 20  3 □ Widowed 4 □ Div	Married	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	s? ¶No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Orig an, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		Race · Ame Black, White Becify: White	e, etc.	
21215-0036	thin 72 hou e. en "natura	Completed	15. De (Specify only Elementary/Secondary (0			r 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most	of worki	ng		of Business/		
2	led wi lygien her th		47 Falbada Nama /Fina N	interfer ( and)	5+		Exe	ecutive	10 Matha	de Nome	(First, Middle,			vernme	nt
Maryland	ould be fii Mental H arked oti etic ever	To Be	17. Father's Name (First, M. Theodore N	lason					Mil.	lice	nt Car	pente	r		
Jar	12 sh n and r is m reum		19a. Informant's Name/Re		•			ng Address (Street a							
	1 and Healtl em 27		Joan M.  20a. Method of Disposition	Mason/	Wife	20b. P	lace of Dispo	9 Steeple sition (Name of					MD 208		
5	ages int of t: If it		1 ∰ Burial 2 ☐ Crem '4 ☐ Donation 5 ☐ Ot		emoval from Stat		ate of	natory or other place Heaven	(a)		1 28,		•		n land
Baltimore,	permit. P Departme Importen eny injur.		21. Signature of Funeral Sc		î Cele		Fr	etery Name and Address ancis J. O Univers		ins 1	Funeral	Home	Inc.	ing, Mar	
			23a. Part1. Enter the disea shock, or heart failure	ise, or compli	cations that caus	ed the death	h. Do not ent	er the mode of dyin	g, such as	cardiac o	r respiratory arr	est,	Spring	Approximate Interval Bets	9
	Physician		Immediate Cause (Final disease or condition	s. List only of	Esopha							•		Onset and I	Death
I	/Medical		resulting in death)			is a conseq									
	Examiner	_	Sequentially list conditions	, l								<u>.                                      </u>			
	ed sit	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	° -{	Due to (or a	is a conseq	derice or).								
	al-trai	xar	that initiated events resulting in death) Last		Due to (or a	as a conseq	uence of):								
8760,	icate be executed physician and s the burial-transit	cal			d										
9	tificat ng phy as th	Medi	(= ==) =												
.O. Box	the death certificate be executed y the attending physician and tched for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	int	3c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of d	I death 3	Ectopic pregnancy Other (specify)				230	I. Date of deli Month		/ear
٥.	that ed b deta		Part II. Other significant co	onditions cor	ntributing to death	but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of d	eath?
ds	puires n sign ald be	d by									1 🗆 Y	es 2 🗆 h	No 3□Pro	obably 4 🛣	Jnknown
Vital Records,	The law requires ate has been sign page 2 should be	Completed									24a. Was a autops perfor	sy med?	prior to death?	topsy findings a completion of ca	available ause of
ital	sicien: Th certificate rector, pag	BeC	25. Was case referred to n examiner?	nedical				-	26. Place	of Death	(Check only or				
of V	ys dir	2	1 ☐ Yes 2 ☒ No	1			ER/Outpatier		4   140		ne 5 Resid			cify)	
		lon:		Pending	28a. Date of Ir (Month, L	njury Da <i>y Year)</i>	28b. Time of Injury	Wor			28d. Describe h	ow injury o	ccurred		
Division	ten leat tor: the	Certification;	3 ☐ Suicide 6 ☐	investigation Could not be determined	28e. Place of I	Injury - At ho	ome, farm, str y)	M 1 []	Yes 2 ☐ Ì		28f. Location (S City or Tow		lumber or Ru	ral Route Num	ber,
	Hospite 4 hours Funerel ely filled	edical Ce	(Check only 2 Me		ner: On the basis	of examina		h occurred at the tin vestigation, in my o							)
	To the within 2. To the Complet	Med	one) 29b. Signature and title of	certifier	and manner	otateu.		29c. Licens	e number		2	29d. Date s	igned (Month	n, Day, Year)	
			1 More	nge	- S	294	$\prec$	D43	083			Λ->	il 26,	2004	
	10		30. Name and address of p	erson who co	ompleted cause of	f death (Iten	п 23а) (Туре,		003			Арг	11 20,	4004	
			George A.					l Center	Drive	, #3	00, Rocl	kvill	e, MD	20850	
	Sta Regist	ate rar	31. Date filed (Month, Day,	8 2004	32. Regis	strar's Signa	ature &	pparks	/						

			1 - For State Registrar	State of Maryla	ind / Depa <i>Ce</i>	artment of H	lealth and <i>Death</i>	Mental Hygi	ene 00 1	15284
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medic		Mildred	<b>T</b> •		McCool		April 24		10:52 P <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	ath	4c. County of De	eeth
			4022 Decatur Ave	nue		Kensing			Montgor	nery
	Funeral		5. Social Security Number 6. S	7V7	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mil		Year) 9. E	Sirthplace (State or Foreign Country) nnsylvania
	Director		201-10-4303	M 20F 85	Yrs.			April 8,	1919 Pe	IIIISYIVAIIIA
	and *	}	Usuel Residence of Decedent  10a, State 10b, County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Aarylan Febow	ō	D.C. Nor	ne W	ashingt	on				1 A Yes 2 □ No
	28a-	Director	10e. Street and Number			10f, Zip Code		10	g. Citizen of What	Country?
	with March		3806 W Street, N	IW		200	07		USA	
	ne 23	Funerai	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No-		merican Indian,
ယ	or Rea	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 2 No		If Yes, specify Cuba		erto Hican, etc.)	Black, W	hite, etc.
03	ral', o	þ	3 Nidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23a or 28a-f ehow the Medical Exancing must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occup- kind of work done of	durina most of w	and down	6b. Kind of Busines	,
2	ithin	jdu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		_	n University
N	ygier ygier tt.		12		Section	etary	10 Matheda N	ame (First, Middle, M	Dental So	:1001
pui	ould be filed within I Mental Hygiene. Narked other then hatic event, the Me	Be	17. Father's Name (First, Middle, Last) Louis Guiteras					<sub>ame (rist, Middle, M</sub> tte Ryan	alden Sumame)	
7 2	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Me	은	19a. Informant's Name/Relationship (	True Brief)	10h Maili	an Address /Street		Rural Route Number,	City or Town State	Zio Code)
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 ehou other traumatic event, the Medical Examinar must be notified as		Jeanette McCool/I					ilver Spri		
o,	1 an Heal Hem 2		20a, Method of Disposition			osition (Name of matory or other place			0c. Location - City	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	Hemoval from State	matory or other place eaven Cem			ilver Spi	ing. Md.	
Ħ	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licer				1 201	eVol Funer		6,
B	Department Department Important in any ir		Henry S.	(For 1)				e.NW.Was		oc 20007
	- 0		23a. Pert 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Breast Car						Onset and Death 3 years
	/Medical		resulting in death)	Due to (or as a cons						J years
2/29/8	Examiner		Sequentially list conditions	b						
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury	Due to (or as a cons	equence of):					
	The law requires that the death certificate be executed the has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a cons	oguana of):					
8760,	cian a	E		Due to (or as a cons	equence on.					
87	physi the t	dical	•	d						
9 ×	death certifica attending ph d for use as the	Physician/Me	IF FEMALE:	23c. If yes, outcome of preg	nancy				23d. Date of d	delivery
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fit	etal death 3[	Ectopic pregnancy Other (specify)	1		Month	Day Year
o.	that the death cer ed by the attendin detached for use	ıysi	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9□ Unknown						
0	that the ned by detac		Part II. Dther significant conditions of	contributing to death but not r	esulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	n signe	Completed by	Hypertensive (	Cardiovascula	r Disea	se		1 □ Ye	s 2 1 No 3 □	Probably 4 Unknown
00	w requir s been si should I	jete						24a. Was an		autopsy findings available
Re	he la e ha:	E					autopsy perform	ed? death	o completion of cause of ? es 2 □ No	
tal		0	25. Was case referred to medical				26. Place of D	eath (Check only one	)	
of Vital Records,	Physician: The lav this certificate has ral director, page 2	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 ☐ Inpatient 2	nt 3 DOA Oth	er: 4 🗌 Nursing	Home 5 ☐ Resider	SON S	residence	
0	neral	ü	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time o	f 28c. Injun Worl	y at k?	28d. Describe how	w injury occurred	
Ö	Attanding r death. ector: Atterby the fune	atle	2 ☐ Accident investigation	n		M 1 🗆	Yes 2 □No			
Division	5 2 5 c 12 4 Nomicle							28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	र विकास कर किया है। जिस्सा के प्रतिकार के									
	The state of the s									
29c. License number 29								d. Date signed (Mo	nth, Day, Year)	
	D26331							٨٠	ril 24 '	2004
	1 -		30. Name and address of person who	completed cause of death (I	tem 23a) (Type.		1.01	A	oril 26, 2	2004
			Marta A. Schneid				d., NW,	Washingto	n, DC 200	016
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		lan 1	,			

			For State Registrar	State of M	arylan				leaith a Death	nd Me	-	giene Reg. No.	2001	15	285
(4)			1. Decedent's Name (First, Middle, L.	ast)						2	2. Date of De		Vaar	3. Time of	Death
	Physici /Medio		Margare	t Saral	1 .	McDani	e1			A	pril	19,	2004	8:55	P.M
	Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City	, Town, or	Location of	Death		4c.	County of Deat	1	
			Wilson Health Ca						rsbur				Montgome		
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7. A⊆ 1 M 2 X F		last birthday)	If Unde Months	Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da	y, Year)		nplace (State or untry)	r Foreign
	Director		5//-01-/618		92	Yrs.					Aug. 1	5 <b>,</b> 1	911 Mis	souri	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Cit	y Limits
	daryl f sho	ō	Manual and Manta		C	od thom	a h	~						1 XYes	2 🗆 No
	28a-	Directo	Maryland   Montgon	ery	<u> </u>	aither		p Code				10a. Citi	zen of What Co	untry?	
	Sa or	ā	403 Russell Aven	# 400				0877					nited Si	•	
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Dec	edent of Hi	ispanic Origi	in? (Speci	fy Yes or No		14. Race - Ame	ican Indian,	
മ	or Ite	F	1 Never Married 2 Married	Armed Forces					in, Mexican,	Puerto Ri	can, etc.)		Black, White	etc.	
8	ral',	1 by	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:			I LI TUS	21KI No	Specify:				Specify: W	hite	
S S	72 h	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Dece	kind of w	ork done o	durina most o	of working	7	16b. Ki	nd of Business/	ndustry	
2	han ne	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life.		use retired	)						
2	tiled within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-1 show yth, the Medical Examener must be maillist at	ပိ	12 17. Father's Name (First, Middle, Las	•1			Cler	k	10 Method	da Noma /	First, Middle,		Distri	ct Cour	t
anc	ntal h	Be			• 1 1 •				16. WOLLIGI	G.					
Ë	hould d Me mark maric	은	Joseph  19a. Informant's Name/Relationship		illip		a Addres	e /Stroot s	and Number	Mary	<b>′</b>	usse	$\perp \perp \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad$	earnow	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic svent, the Medical Examiner must be notified at ODGe.		Janice Didawick/				-							p 000 <del>0</del> )	
ē,	1 an Heal Iem 2		20a. Method of Disposition	Cousin	20b. P	lace of Dispo	sition (Na	me of		Dai			7 25411 cation - City or	Town, State	
altimore,	Sont of		1 Burial 2 Cremation 3 Control of the Control of t			semetery, crer				10011	2001	C	+1and ·	Warra am	3
	artme ortan injur		21 Signature of Funeral Service Lice		100	lar Hil			s of Facility	/23/2	2004 ol Fun		tland,	Maryian	.a
B	Den Imp		Muelin	as lu	Jul								sburg, 1	VID. 208	77
g.	_		23a. Part1. Enter the disease, or cor	plications that cause	d the deat								July,	Approximate	
100	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ine. ~ P ~	+:-								Interval Betw Onset and D	eath
	/Medical		disease or condition resulting in death)	a. Due to (or as	a conseq	uence of):								Year	5
4	Examiner													1	
A))		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseq	uence of):									
	cuted	Examiner	Cause (Disease or injury that initiated events	c											
Ö,	e exe ian a urial-		resulting in death) Last	Due to (or as	a conseq	uence of);									
8760,	The law requires that the death certificate be executed the second signed by the attending physician and orgoe 2 should be detached for use as the burial-transit	Physician/Medical	•	d									-		
9	leath certifica attending pl	Mec	IF FEMALE:	22a Huan autaana									1		
Вох	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	I death 3		regnancy				2	3d. Date of deli Month	,	ear
	the de	ysic	1 □ Yes 2 🖾 No 9 □ Unknown	4□Pregnant a 9□ Unknown	t time or o	eath 5	Other (s	респу)		·					
0.0	res that the de igned by the a be detached t	H	Part II. Other significant conditions	contributing to death t	out not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco u	se contribute to	the cause of de	ajh?
ds	uires sign ld be	d by									101	res 2[	No 3□Pro	bably 4 Du	nknown
000	w require been si should I	lete			T						24a. Was	an	24h Ware aut	opsy findings a	vailable
Re	he law s has ge 2 a	Completed									autop		prior to c death?	ompletion of ca	use of
a	ician: Th certificate rector, pag	e C	25. Was case referred to medical	I					00 Plane	-4.0		2 1 No	1 🗆 Yes	2 No	
>	Attending Physician: r death. ector: After this certifica by the funeral director. I	To B	examiner?	Hospital: 1  Inpati	ant 2	ER/Outpatien	t 3 🗆 D	OA Othe	00		Check only o		☐Other (Spec	(6.1)	
ō	y Phys ar this eral di		27. Manyer of Death	28a. Date of Inju	ıry	28b. Time of		28c. Injury Work			d. Describe h			119)	
ō	nding lath. r: After e funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ly rear)	Injury	М		r Yes 2 □ No	lo					
Division of Vital Records,	er degreeto	Certification:	3 Suicide 6 Could not lead to determine determined				eet, facto	y, office		28	f. Location (S City or Tox		Number or Ru	al Route Numb	197,
Ö	tal or	Cer		55	io. (Opcon)	,,					0.1, 0, 10.1	,, olato,			
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis of	of my kno	wledge, death	occurred	at the tim	e, date and	place, and	d due to the	cause(s)	and manner as	stated.	
	the Hin 24 the Fin 24 the Final Inches	ledi	one)	and manner st	ated.										
	witi To	Σ	29b. Signature and fitte of certifier	)0-			29	c. License	number	<b>&gt;</b>		29d. Date	signed (Month	Day, Year)	1
•	10		1 / / / /	John	hr			U- 0	ナリフ	D		46	11 20	1 200	7
	1.		30. Name and address of person who		teath (Item	23a) (Type,	Print)	CU A	MANINA	9	6 auth	erst	1/ 20	Md 20	0877
	Sta	to	31. Date filed (Month, Day, Year)	32. Registr		iture 🚄	. ~0.5	, ,	10 01100				7.7		
	Sta Registr		APR 272		مصمع	B	de	acks							

		•	For State Registrar	State o	f Maryla	nd / Depa	artmen rtificate				lental Hy	giene	2 n n t.	15286
	Ol		Decedent's Name (First, Middle, Li	ast)				,			2. Date of De			3. Time of Death
	Physici /Medic		Pauline L. Mck								April	26,	2004	2:35 A M
	Examin	er	4a. Facility Name (If not institution, gi						Location of				County of Dea	
	F		Brooke Grove Rehabil	itation &		g Center s. last birthday)			prine		8. Date of Bi	rth	Montgom 9. Bir	
	Funeral Director			1□M 2\F	9:		Months	Days	Hours	Min.	June 5	ay, Year)	12 Pen	thplace (State or Foreign ountry)
	pu *		Usual Residence of Decedent  10a. State 10b. County		100.0	City, Town or Lo	ocation							10d. Inside City Limits
	Aaryla f aho	or		0.03477		ckville								1 ☐ Yes 2 ☒ No
	r 28a-	Directo	Maryland   Montgon	шегу		CKVIIIE	10f. Zip	Code				10g. Cit	izen of What Co	ountry?
	th with		13609 Loree Lane	2			20	853				Uni	ted Sta	tes
	r dea	Funeral	11. Marital Status	12. Was Dec Armed Fo 1 □ Yes	edent Ever in	U.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Ame Black, Whi	erican Indian,
20	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Wildowed 4 ☐ Divorced	1 □Yes If Yes, Gir Year or D	/8		1 ☐ Yes 2	2 <b>∑</b> No	Specify:				Specify:	
212-0036	within 72 hours after death with the Maryland ene. Itan "natural", or items 23a or 28a-f ahow he Medical Examinal must be notified at	ted t	15. Decedent's E	ducation	a.65.	16a. Dece	dent's Usua	I Occupa	ition			16b. K	ind of Business	nite Undustry
מ	thin 7.	Completed	(Specify only highest gi	rade completed) College (	1-4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired)	luring mos )	t of worki	ng			
7	ygien ygien ner th	Con		4		Неа	d Mis					1	urch Sc	hool
מש	otal H	Be	17. Father's Name (First, Middle, Las	t)							(First, Middle	, Maiden	Sumame)	
Maryland	hould d Mer mark	ဥ	William Lesher  19a. Informant's Name/Relationship	(Type Print)		19b Maili	na Address	(Street a		Smi		er City o	r Town, State,	Zin Code)
<u>8</u>	nd 2 s lith an 27 is r trau		Thomas A. McKins										, Maryl	
<u>o</u>	of Hear item		20a. Method of Disposition		20b.	Place of Dispo	sition (Nan	ne of ther place		pril			ocation - City or	
Ē	Page ant: If		1 ☐ Burial 2 🖔 Cremation 3 i 1 ☐ Donation 5 ☐ Other (Spec		State Mo	ntgome	ry	T m o	i 2	2004		Beth	nesda, N	Maryland
Baitimore,	permit. Pages 1 and 2 should be filed within 7 Department of Healin and Menial Hygiene. Important: If tiem 27 is marked other than "any injury or other traumatic event, the Heal once.		21. Signature of Funeral Service Lin	ensee		0803 R	2. Name an ockvi ockvi	d Addres 11e, 11e,	s of Facilit Inc. Mary	y Rol 300 land	ert A. West 2085	Pum Mont	phrey F Jomery 05	uneral Home/ Avenue
F			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that it	used the dea									Approximate Interval Between
. 1	Physician		Immediate Cause (Final disease or condition	-a. Acur	E CER	ETERAL :	INFAR	CT						Onset and Death  Z WCEES
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):								
	ā d	-	Sequentially list conditions,	b. Due to	(or as a conse	outence off:								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,								
o,	be executed ician and burial-transit		resulting in death) Last	c. Due to	(or as a conse	equence of):								
2/6U	ate be executed hysician and the burial-transit	Ical		d										
õ ×	death certificate e attending phys id for use as the	Med	IF FEMALE:	23c. If yes, out										
ROX	attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live b	inth 2 □ Fe ant at time of	tal death 3	Ectopic pro					1	23d. Date of de Month	livery Day Year
j.	the de ny the ached	nysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unkn		dout, 3	2000 (3)	<i>buny</i> /	_					
ds, r	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions	contributing to d	eath but not re	sulting in the u	nderlying ca	ause give	n in Part I.					o the cause of death?
cords,	w requ	lete				-					24a. Was	20	24h Were at	utopsy findings available
ř	The ate ha	Completed									auto		prior to death?	completion of cause of
VII	i <b>ician</b> : Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	Hospital:			7,	0.1	-		(Check only			
0	Physical this call dir	٠ <u>۲</u>	1 ☐ Yes 2 💆 No 27. Manner of Death	10		ER/Outpatier		A lound	" 4⊠Nu		ne 5 Resi		6 □Other (Spe	cify)
0	ding h. After funer	tlon	1 ⊠Natural 5 □ Pending 2 □ Accident investigation		of Injury th, Day Year)	Injury	M	8c. Injury Work	?ີ່ ′es 2 ⊡≀		ed. Describe	now injui	y occurred	
DIVISION	or Atten after deal Director in by the	Certification;	3 Suicide 6 Could not determined	28e. Place	of Injury · At ng, etc. (Spec	home, farm, str cify)	reet, factory	, office		2	28f. Location ( City or To	Street an wn, State	d Number or Ru )	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after dear Attentine certifics To the Funeral Director After this certifics completely filled in by the funeral director.	edical Ce	29a. Certifier 1 Certifying P	miner: On the b	asis of examin	nowledge, death	h occurred a	at the time	e, date an	d place, a	and due to the ed at the time,	cause(s)	and manner as	s stated. to the cause(s)
	o the ithin 2 o the smple	Med	one)  29b. Signature and title of/certifier	and man	ner stated.		29c	. License	number			29d. Dat	e signed (Mont.	h, Day, Year)
	10		18thans	M			1	337	700			Α	L Z6.	
	1.		30. Name and address of person who	completed caus	se of death (Ite	em 23a) (Type,	Print)							
			TED HOWE	154 N	\$ 1 done 1		ST. I	WILL	IAMS	PORT	, MD	15	795	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 20		egistrar's Sign	nature	Space	K	ý					

			1- For State of Maryland / Department of Heal Certificate of Dea			jiene <sub>eg. No.</sub> 2001	1528
	Physici		1. Decedent's Name (First, Middle, Last)  Cleo B. Morrill		2. Date of Deat April	23, 2004	3. Time of Death 12:19A. M
	/Medic Examir		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Loca Washington Adventist Hospital Takoma Pa	_		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, July26,	, Year) 9. Birth Co. , 1910 Kan	hplace (State or Foreign untry) Sas
	the Maryland 28a-f show notified at	rector	10a. State 10b. County 10c. City, Town or Location		10	Og. Citizen of What Co	10d. Inside City Limits 1√2 Yes 2 □ No untry?
336	hours after death with the Maryland tural", or flams 23a or 28a-f show al Examiner must be notified at	Completed by Funeral Director	2012 Brighton Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  20782  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No Sp. If Yes, Sive Year or Dates:	nic Origin? (Spec lexican, Puerto R pecify:	ify Yes or No-	United Sta  14. Race - American Black, White Specify: W	rican Indian,
121215-0036	d within 72 liene. r than "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12 College (1-4or 5+) Analyst	g most of working	g	16b. Kind of Business/I	
Maryland	o ta de	To Be	Honry D. Morrill	lanche S	usan Bo		in Code)
	1 and 2 Health a om 27 is ther tra		Mildred L. Morrill -wife 2012 Brighton Ro  20a. Method of Disposition (Name of cemetery, crematory or other place)	oad Hyat	tsville	e, Maryland 20c. Location - City or T	20782 Town, Stete
Baltimore,	permit. Pages Department of Important: If it any injury or o		The Burnal 2 Cremation 3 Hemoval from State Fort Lincoln Cemeter  1 Donation 5 Other (Specify)  21. Signature of Funeral Service Lice For Donald V. Bor 4400 Powder M.	Facility rgwardt	Funeral	Brentwood, Home, P.A	
8760,	Anysteien and wasteien and wasteien and wasteien and the burial-transit	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter third or highly Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	uch as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
.O. Box 6	law requires that the death certiticate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown			23d. Date of deliv	very Day Year
Records, P.	e law requires that has been signed b je 2 should be deta	Completed by Pt	Part ii. Other significant continuous continuum to death but not resulting in the underlying cause given in i	Part I.	23e. Did tob  1  Ye  24a. Was ar autopsy	n 24b. Were aut	
Vital	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	Place of Death	Check only one	No 1 ☐ Yes	2 □ No
Division of	or Attending Ifter death. Director: After in by the tune	Certification; T		28 2 □ No	8d. Describe ho	w injury occurred reet and Number or Rui	
-	To the Hospitel or At within 24 hours after of To the Funerel Direct completely tilled in by	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, da 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion and manner stated.	n, death occurred	d at the time, da	ate and place, and due	to the cause(s)
	To t withi To t com	W	29b. Signature and title of certifier  29c. License num  29c. License num  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  7 (600)	mber 15/2/	29 Y	and Date signed (Month)  April 23  Aire	Day, Year)
	Sta Registi		BRIAN F. REACHN TOLOGO 31. Date filed (Month, Day, Year) APR 27 2004  APR 27 2004  Apouls	a T	tuk	may	ke-\

State of Maryland / Department of Health and Mental Hygie  1 - State												1.	15200	
	Dharisi		1. Decedent's Name (First, Middle, Last)							Reg. No L. U U U J S S S S S S S S S S S S S S S S				
	Physici /Medic	al	John Hallett Mulliken, Jr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death								,		5:10 PM M	
	Examin	er	5630 Wiscons		#301			Chevy		2			omery	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8 Min.	. Date of Birth (Month, Day, Y	(ear) 9.		ace (State or Foreign	
	Director		109-16-3865 Usual Residence of Decedent		81	113.			J	uly 17,	1922	<u>I1</u>	linois	
	arylan show	-										od. Inside City Limits 1 X Yes 2 □ No		
	the M. 28a-f	Director	Maryland Montgomery Chevy Chase  10e. Street and Number 10f. Zip Code						nase	100	g. Citizen of Wha	t Count	· · · · · · · · · · · · · · · · · · ·	
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show te Madical Examirer must be notified at	al Di	5630 Wisconsin Avenue #301 20815 United States							•				
		Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sr. If Yes, specify Cuban, Mexican, Puerto							fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.			
036	urs aft	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates: Ţ		1	☐ Yes 21X No	Specify:			Specify:	Wh	ite	
21215-0036	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	ation		(Give	ent's Usual Occup	during most	of working	16	6b. Kind of Busin			
121	within ene. then	ompi	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	OO NOT use retired [Journa				D111	h1ic	hing	
nd 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiene.  Department of Healih and Mental Hygiene.  Department of Healih and Mental Hygiene.  The Marylant of the 27 is marked other than "naturel", or litems 23a or 28a-1 show eny injury or other treumetic event, the Maryland Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last)	<del></del>			Journal		r's Name (I	First, Middle, Ma		DITE	oning	
ylaı			John Hall								e Mille			
Maryland			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Helen Burr Curtice/Stepdaughter  5164 Fulton Street N.W. Washington, D.C. 20016											
ore,			20a. Method of Disposition		20b. Place of	of Dispos	sition (Name of natory or other place	ce)	Dat		c. Location - Cit			
Baltimore,			Montgomery April Crematorium Inc. 29. 2004 Bethesda, Marvland											
Bal	Departiment of the particular		21. Signature of Funeral Service License	,	M00335	Be Be	Name and Addre thesda-Cl thesda. N	ss of Facility nevy (Marv1a	chase and 20	Inc. 7 0814-350	imphrey 557 Wis	cons	eral Home/ sin Avenue	
	whysician and hysician and ithe burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
			Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Onset and Death											
			f .		a consequence	of):								
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (is see of the part of th											
8760,	icate be e physiciar s the buri	dicai E	d											
9	ertifica ding ph	/Med	IF FEMALE:	a Muse suterme			•				1			
Вох	death certific e attending p id for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1								23d. Date of Month	23d. Date of delivery  Month Day Year		
Records, P.O.		hysi												
	es De	by	259. Did tobacco use contribute to the contributing in the underlying cause given in Part i.								cause of death?			
	Physicien: The law requir this certificate has been siral director, page 2 should	lete								24a. Was an			sy findings available	
		Certification; To Be Completed								autopsy performe 1 ☐ Yes 2 ∑	d? deat	to com h? Yes 2	pletion of cause of !□ No	
Vital			25. Was case referred to medical examiner?	ospital:			Oth			Check only one)				
0	g Phys er this eral di		The input of the companion of the compan											
sion	l or Attending F after death. Director: After I'n by the funer.		1 XNatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No											
Division of		ertifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier  (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	and manner sta	ted.	10000			n occurred				` '	
•	F 3 F 8	-	29b. Signature and title of societies  29c. License number  D22086							Date signed (Month, Day, Year)  April 29, 2004				
	12		30. Name and address of person who con	Neted duse of de	eath (Item 23a)	(Туре, F	Print)	שעעטא	0		Apri	L 29	, 2004	
			Frederick P. Smith, 31. Date filed (Month, Day, Year)		54 Wisc	onsi			0 Che	vy Chase	e, Maryl	and	20815	
	Sta Registr		APR 3 0 2004	- ner	1	9	Sparks	/						

			T = For State Registrar	State of N	Maryland		artment rtificate			and M		giene Reg. No.2	004	15289
	Physici		Decedent's Name (First, Middle,  GRETTA FREDER)		ASH						2. Date of Dea Month APRIL	Day	2004	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution,	give street and number	r)		4b. City, T	own, or	Location of	of Death		4c. Count	ty ol Death	
			Dorchester Ger	veral Ho	spital				BRID				Chest	Ler
	Funeral Director		508-07-5548	3. Sex 1 □ M 2X F	Age (In yrs. Ias 82	Yrs.	If Under 1 Months	Year Days	If Under	Min.	8. Date of Birt (Month, Da) AUG 17	1921	9. Birthpl Count NEBF	lace (State or Foreign trx) ASKA
	land ow ft		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation						11	Od. Inside City Limits
	Mary 1 sh	ţō	MD TAL	BOT	7	EASTO	N							XXYes 2□No
	n the	Director	10e. Street and Number		~		10f. Zip 0	Code				10g. Citizen of	What Coun	try?
	23a (		640 MECKLENBUR	G AVE.				216	01				USA	
336	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28s-f show svent, the Medical Exercises must be inclified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ XWidowed 4 □ Divorced	12. Was Deceder Armed Forces d 1 Tyes 2X If Yes, Give Year or Dates	s? ] No		Was Decede If Yes, specif 1 ☐ Yes 🎉	fy Cubar	spanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		ace - America ack, White, e ify: WH	
5-0036	72 hor	Completed	15. Decedent's	Education		16a. Dece	dent's Usual kind of work	Occupa	tion	of working	20	16b. Kind of E	Business/Ind	lustry
21	ithin 7	npie	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use	retired)	uning most	OF WORK	,g			
N	filed w Hygien ther th		12	2			COME			d- Nom-	(Fina Adiabata		RUG SI	TORE
Maryland	d be fi	Be	17. Father's Name (First, Middle, La TOM FREDERICKSO)								(First, Middle, SCHLIS		me)	
2	should be nd Menta i marked umatic sy	ဥ	19a. Informant's Name/Relationship			19b. Mailir	ng Address (	Street a			Route Numbe		State Zin	Code)
	s 1 and 2 should f Health and Men item 27 is marke other traumatic		S.W. MCCASH/SON				68 CLU					N, MARY		
altimore,	es 1 ar of Hea of Item fitem		20a. Method of Disposition		l com	e of Dispo	sition (Name	e of			ate	20c. Location		
Ĕ	Pages nent of int: if its iry or o		1 ☐ Burial 2 X Cremation 3  1 ☐ Donation 5 ☐ Other (Spe		.0	•	•			R 4-	28-2004	STEVE	ENSVII.	LE, MD
alti	permit. Pages 1 ar Department of Hes Important: If Item eny injury or othe once.		21. Signature of Funeral Service Lic	censee	· · · · · · · · · · · · · · · · · · ·	22	2. Name and	Address	of Facility	v	& NEWN			
<u> </u>	89729		JOHN A	? MER	CER	> 1	00 S.	HARI	RISON	ST	EASTON,	MD 216	601	TOTIS IA
	Physician		Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each	line							rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	nic Oi s a consequer	To	bacc	0	USE	2	J			
	outed ansit	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	is a consequer	nce of):							1	
8760,	ate be executed nysician and he burial-transit	licai Exa	resulting in death) Last	Due to (or a	s a consequer	nce of);								
89	tificat ng phy as th													
P.O. Box	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown		ie of pregnancy 2  Fetal de at time of deat	eath 3	Ectopic pred Other (spec					I	ate of deliver onth [	ry Day Year
	law requires that the der as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions Congestw	s contributing to death Life	1	- /		use give	n in Part I.					e cause of death? ably 4 □Unknown
ဝင္ပ	law re as bee 2 sho	Completed	0								24a. Was a			sy findings available
Ĭ	The ate h page	Com									perfor	med?	death?	28 No
ıta	cian: ertific ector,	Be (	25. Was case referred to medical examiner?	11-201				_		of Death	(Check only or	18)		
5	Physician: The lar r this certificate has aral director, page 2	٦	1 Yes 2 No	Hospital: 1 Hipa		VOutpatien			4 🗀 1401	-	ne 5 Resid			)
ב ס	ding l h. After funer	tion	1 □ Natural 5 □ Pending	(Month, D	lay Year)	Bb. Time of Injury	M 200	C. Injury Work	at ? es 2 □ N		8d. Describe h	ow injury occur	rea	
Division of Vital Records,	To the Hospital or Attending Physician: state as after death as a state death or the Funeral Birector, After this certifica completely filled in by the funeral director,	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	t be 28e. Place of I	njury - At home etc. <i>(Specify)</i>	e, larm, str					8l. Location (S City or Town		ber or Rural	Route Number,
_	To the Hospital within 24 hours and the Funeral I completely filled	edical Ce	(Check only 2 Medical Ex	Physicien: To the best teminer: On the basis	at of my knowle	edge, death	n occurred at	the time	e, date and	d place, a	nd due to the c	ause(s) and ma	anner as sta	ited.
	thin 2 thin 2 o the	Med	one) 29b. Signature and title of certifier	and manner s			29c. I	License	number		2	9d. Date signe	ed (Month. C	Dav. Year)
	F ≯ F 8		Michael		you	ク	D	36	86	O	oc, us	4/281	104	
			30. Name and address of person when MICHAGE P. M.	orita inc	death (Item 23	3a) (Type,	Print) RAS	7.	CAME	56100	oc, Mb	2161	13	
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	8 <b>2004</b> 2	trar's Signature	A. 1	ford	1						

1.

MICASH, GRETTA

			1 – For Registrar	State of M	aryland / De	partmer <i>ertifica</i> :					giene	nnl	15	291
			Decedent's Name (First, Middle, Las	1)						2. Date of Dea	ith	003	3. Time	of Death
	Physic		Charles	Loren	М	adigan				Month April	25, 20	Year 04	8:0	0 A <sup>M</sup>
	/Medi Examir		4a. Facility Name (If not institution, give					Location	of Death	P		nty of Deat		0_21
			16 Congress Aven	ue			]	Deer	Park			Garr	ett	
	Funeral		5. Social Security Number 6. Se	7. Ag	ge (In yrs. last birtho	(ay) If Under	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birti (Month, Day	Year)	9. Birtl	nplace (Stat	e o <i>r For</i> eign
	Director		214-162458	MM 2□F	83 Yrs	i. IVIOTILITS	Days	Tiodis		April 2			ary1a	
	p ,		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town o	r L acation							10d Inside	City Limits
	aryla shov	_	Toa. State		Toc. City, Town o	Location								es 2 No
	Ba-f	ctc		rrett			eer ]	Park						
	vith th	Dire	10e. Street and Number			10f. Zi	p Code		_		10g. Citizen		,	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "naturel", or items 23a or 28a-f show other treumetic event, the Medical Examinar must be notified at	by Funeral Director	16 Congress Aven					2155			144.5	USA		
	er de item	une	11. Marital Status	12. Was Decedent Armed Forces?		If Yes, spe	dent of Hi cify Cuba	ispanic Ori in, Mexicar	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14. F	lace - Ame lack, White	rican Indian e, etc.	
36	s aff	Ϋ́F	1 ☐ Never Married 2 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No	1 🗆 Yes	2🄼 No	Specify:			Spe	cify: W	hite	
21215-0036	hour turei	pa	15. Decedent's Ed		16a D	ecedent's Usu	al Occup	ation			16b. Kind of	Rusiness/	ndustry	
15	in 72	Completed	(Specify only highest grad	de completed)	(G	ive kind of wo	ork done d	durina mos	t of worki	ng	TOO. IKING O	Daginosa	industry	
12	with ene.	E C	Elementary/Secondary (0-12) 9th	College (1-4or	5+)		For	reman			во	rai1	road	
9	filed Hyg other		17. Father's Name (First, Middle, Last)				10,			(First, Middle,			LUAU	
Maryland	d be ental ked c	To Be	Charles He	enry	Madigan			Car	rie	Mae		Hineb	augh	
<u> </u>	shoul nd Me mark	Ĕ	19a. Informant's Name/Relationship (7			ailing Address	s (Street a			I Route Numbe				
Ma	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any injury or other treumetic event, the Meonce.		Alice M. Madigan	/daughter						eer Parl				
ē,	Hea Hea tem		20a. Method of Disposition	dadalect	20b. Place of D	sposition (Na	me of			ate	20c. Locatio			
Baltimore,	ages ant of t: If i		1 ဩ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			crematory or	•		1.100	2/0/	D	D 1		
Ξ	iit. Partme	ŀ	21. Signature of Furneral Service Lights		Deer P	22. Name a					Deer :			Land
Ba	Department Department of the propertment of the pro		D 2 10 1 A							tewart ] Jakland			e	
			23a. Part1. Enter the disease, or comp	lications that cause	d the death. Do not					100		21330	Approxin	ate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Corona	ary Arter		ase						Interval 8 Onset an Year	d Death
	Examiner				a consequence of):								Year	
		<u>~</u>	Sequentially list conditions,	0.	tes Melli:								1ea.	
	nsit	dicai Examiner	if any, leading to immediate cause. Litter Underlying Cause (Disease or injury											
_65	cate be executed physicien and the burial-transit	xai	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):									
8760,	sicier buri	ä		d										
687	ficate phys			d										
	The law requires that the death certifics are has been signed by the attending pt bage 2 should be detached for use as It	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy						23d. [	Date of deli	verv	
Вох	that the death cer ed by the attendir detached for use	ciar	in the past 12 months?	1⊡Live birth 4⊡Pregnant a	2 Fetal death	3 ☐Ectopic p 5 ☐ Other (s)						Month	Day	Year
P.O.	y the	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown			,,							
	that the od by detac	4	Part II. Dther significent conditions co	entributing to death t	out not resulting in th	e underlying	cause give	en in Part I		23e. Did to	bacco use co	ontribute to	the cause of	f death?
ds	signe signe	Q P								1 D Y	es 2 No	3 🗆 Pro	bably 4	∐Unknown
ò	w require been signature	Completed by								24a. Was a	24	More au	topsy finding	ne available
3ec	e lav	m d		<del></del>				_		autop	SV	prior to c death?	ompletion o	cause of
1	: Th	ပိ	and the second s								2 No	1 🗆 Yes	2 □ No	
of Vital Records,	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	0.51		(Check only or				
of	this a	2	TE THE ZE THO	1 U inpati			JA	4 🗆 140		ne 5 Besid			ify)	
L C	ing F	o	27. Manner death 1 death 5 □ Pending	28a. Date of Inju (Month, Da	ary Year) 28b. Tim Inju		28c. Injury Work			28d. Describe h	ow injury occ	urreg		
Division	f or Attending Physicien: The lavalter death. Director: Atter this certificate has	Certification:	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2□		206 Lanation (C	to at and thu		ent Clause At	
₹	or At after of Direction by	E	4 Homicide determined	288. Place of in	jury - At home, farm tc. <i>(Specify)</i>	, street, factor	у, опісе		· ·	28f. Location (S City or Tow	n, State)	nder or Hu	rai moute iv	umber,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the			/sicien: To the best										a(s)
	the F iin 24 the F iplete	edical	one)	and manner st	ated.				Sesant					
	with To	Σ	29b. Signature and title of certifier			29	c. License	number		2	29d. Date sign	ned (Month	Day, Year	,
•			· III					D1533	33		41	LVV	4	
			30. Name and address of person who o	completed cause of	death (Item 23a) (Ty	pe, Print)					1		1	
		1	Thomas G. Johnson	-		4th St	., 0	aklar	nd, M	ld. 2155	0			
	Sta	ate	31. Date filed (Month, Day, Year)  ADD 2.8.7	32. Prégistr	rar's Signature	Social	r						1	

			1 - State Registrar	and / Department of Health an  Certificate of Death	d Mental Hygier	2001 10001
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last)  Joel Benjamin Miller  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D	04 28	Day Year 3. Time of Death 13:10 M
	Funeral Director			rs. last birthday) If Under 1 Year If Under 24 Months Days Hours N	Hrs. 8. Date of Birth (Month, Day, Yea July 22, I	Allegany  9 Birthplace (State or Foreign Country)  1952 Pennsylvania
	the Marylan 28a-f show	Director	10a. State 10b. County 10c.  Maryland Garrett  10e. Street and Number	City, Town or Location  Grantsville  10f. Zip Code		10d. Inside City Limits 1 ☐ Yes 2 🕍 No
036	d within 72 hours after death with the Maryland jiene. rithan "natural", or Itams 23a or 28a-1 show the Madreal Examirar must be mailfied at the Madreal Examirar must be mailfied at	by Funeral		21536		USA  14. Race - American Indian, Black, White, etc.  Specify: White
2121	d within giene. r than *	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Laborer	working	Kind of Business/Industry etail Store/Yoder's Locker
Maryland	d tal	Be	17. Father's Name (First, Middle, Last)  Daniel M. Miller  19a. Informant's Name/Relationship (Type, Print)		Name (First, Middle, Maide  M. Schrock  Rural Route Number, City	
imore,	permit. Pages 1 and 2 should Department of Health and Men Important: If itam 27 is marke any injury or othar traumatic <u>once.</u>		125 Dunial 2   Oremation 3   Hemoval nom State	186 Coal Run Road, Months of commetery, crematory or other place) erry Glade Cemetery April 22. Name and Address of Facility Newman Funeral Ho	Meyersdale, E Date 2004 Fil 26, Acc	
	nysician /Medical Examiner		resulting in death)  Due to (or as a cons	RAZ PUENMONIA Gequence of):	diac or respiratory arrest,	Arryland 21536 Approximate Interval Between Onset and Death
8/60,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a considerable provided in the constant of the constant of the constant of the constant of the cause of t			
P.O. BOX 0	that the death certific ed by the attending p detached for use as t	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant at time of 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not re  CONCESTIVE HEART FAIL	resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐Unknown
r	uctan: The law i certificate has bi rector, page 2 sh	e Completed by	ACUTE JANA FALLUM 25. Was case referred to medical		24a. Was an autopsy performed?	
5	ding Phys	ToB	examiner?  1 Yes 2 No  27. Manner of Death 1 Pending 2 Accident investigation  Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	☐ ER/Outpatient 3☐ DOA Cther: 4☐ Nursing 28b, Time of 28c, Injury at	Death (Check only one)  g Home 5  Residence 28d. Describe how inju	
֡֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֟ <b>֭</b>	To tha Hospital or Attan Within 24 hours after deat To tha Funaral Diractor: completely filled in by the	sal Certification;	29a. Certifier 1 Certifying Physician: To the best of my ki	nowledge, death occurred at the time, date and pla	City or Town, Star	c) and manner as stated
1	To the Ho within 24 To the Fu completel	Medical	(Check only 2 Medical Examiner: On the basis of examinand manner stated.  29b. Signature and title of certifier	nation and/or investigation, in my opinion, death oc	courred at the time, date an	ate signed (Month, Day, Year)
	2		30. Name and address of berson who completed cause of death (its VIRCINIA C. MR 170 JOS M.  31. Date filed (Month, Day, Year)  32. Registrar's Sign		PRIVE CIM	PRIL 22, 2004 r PATRIAND, MD 21100
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 6 2004  32. Registrar's Sign	M. Amaril a		

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For Stete Registrer	State of Maryla	•	artment of rtificate o		·	giene Reg. No 20 (	15292
ı	Physici /Medi		Decedent's Name (First, Middle, Last)     EUGENIE (NMI)	MAC FARLI	NE			2. Date of De Month	ath found 25, 2004	9:15 AM
	Examir	ner	4a. Facility Name (If not institution, give s 2026 SPRING LICK			4b. City, Town	or Location of D		4c. County o	
ì	Funeral Director		141-24-3781	7. Age (In yrs	s. last birthday) Yrs.	Months Day		lin. 8. Date of Bir (Month, Da OCT 13	y, Year) 1925	9. Birthplace (State or Foreign Country) GERMANY
	death with the Maryland ms 23a or 28a-f show croust be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD GARRETT		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	i Direc	10e. Street and Number 2026 SPRING LICK R	OAD		10f. Zip Code	561		10g. Citizen of Wh	
320	or Ite	by Funeral Director		12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of	Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	Black	- American Indian, , White, etc. WHITE
21215-0036	within 72 ho ane. than "natu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of	working	16b. Kind of Bus	
yland	should be filed and Mental Hygie marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)  (UNKNOWN)	DIETZEL			(UNK	Name (First, Middle, NOWN)		,
тоге, маг	and 2 salth a n 27 ls		19a. Informant's Name/Relationship (Typ.  CYNTHIA MOONEY - D  20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Re	AUGHTER 20b.	Place of Dispo	Sition (Name of matory or other p	LLS S.	LAUREL, Date	MD 20724 20c. Location - C	City or Town, State
Baltim	permit. Pages 1 Department of He Important: If iten any injury or oth		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funehal Service License			2. Name and Add	ress of Facility	27/04 P.O. ME - OAKL	MORGANTO BOX 243 AND, MD	war coulden
	Cate be executed  Abysician and  Abysician and  Cate be executed	al Examiner	23a. Pant 1. Enter the disease, or complications, shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tany, loading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	IEROSCLI equence of):			VASCULAR		Approximate Interval Between Onset and Death YEARS
O. Box 667	death certifi e attending p id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 \( \o \o \o \o \o \o \o \o \o \o \o \o \o	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnan			23d. Date Monti	
ras, P.	es tha		Part II. Other significent conditions con	tributing to death but not re	esulting in the u	nderlying cause g	given in Part I.			oute to the cause of death?
II Records	The law ate has b page 2 sl	Completed						24a. Was autop perio 1  Yes	sy pri	ere autopsy findings available or to completion of cause of ath? ] Yes 2 [] No
VII	Physicien: this certific ral director.	o Be	25. Was case referred to medical examiner?  1 X Yes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Whor	Death (Check only only only only only only only only		(Specify)
	ng ille	ation; T	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	uryat ork? ⊒Yes 2 □No	28d. Describe h	ow injury occurred	d
Division	To the Hospitet or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office	8	28f. Location (S City or Tox		or Rural Route Number,
	ne Hosp n 24 hou ne Fune oletely fil	edicai	29a. Certifier 1 ☐ Certifying Phys (Check only one) 1 ☐ Medical Examin	ician: To the best of my kr ler: On the basis of examir and manner stated.	nowledge, death nation and/or in	n occurred at the vestigation, in my	time, date and pla opinion, death of	ace, and due to the courred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the Vithin 2 To the Complet	Σ	29b. Signature and title of certifier	melle		29c. Lice H26	nse number			(Month, Day, Year) 26, 2004
	10		30. Name and ddress of person who come P. DANIEL MILLER,			Print) ES DRIVE	OAKLA	ND, MD 21	550	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	A . 16 .				

ORIGINAL

			1 - State Registrar	State of Maryla	•	artment of F ertificate of			giene leg. No. 2001	+ 15293
	Physici /Medio		Decedent's Name (First, Middle, Last)     GEORGE	Α.		NITZ		2. Date of Dea Month May 2	Day Day Year	3. Time of Death 9:35 a M
	Examin		4a. Fecility Name (If not institution, give of Univ. of Maryla	street and number) nd Medical	Syst	4b. City, Town, c Balti	r Location of Death MOTE	1	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 1X 223-10-9701 Usuel Residence of Decedent	M 2DE	s. last birthday 90 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day March 2	r, Year) Co	thplace (State or Foreign ountry) nnsylvania
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show appring or other traumatic event, if a M. Lical Examination and be notified at ance.	To Be Completed by Funeral Director	10a. State 10b. County  MD Cecil  10e. Street and Number  205 Frock Lane	12. Was Decedent Ever in Armed Forces?  1 XYes 2 □ No If Yes, Give Year or Dates:  194. Cation a completed)  College (1-4or 5+)  Type, Print)  Lemoval from State	U.S. 13. L-45  16a. Decc. (Giv. iffe. Wate	wingo  10f. Zip Code  219  Was Decedent of If If Yes, specify Cub  1 Yes 2 No  edent's Usual Occup  a kind of work done  DO NOT use retire  Plant  ing Address (Street  Freck Language of the plant  with Memoria  We Memoria  22. Name and Address  23. Name and Address  24. Name and Address  25. Name and Address  26. Name and Address  27. Name and Address	dispanic Origin? (San, Mexican, Puert Specify:  Dation during most of word 18. Mother's Nar  Can and Number or Ru  ue, Conord Hay sss of Facility R.	pecify Yes or No- o Rican, etc.)  Is me (First, Middle, coline Blural Route Number Mingo, MI Date  7,2004  T. Foard	Specify: Wh  16b. Kind of Business  U.S. Gove  Maiden Surname)  Land  r, City or Town, State, A	ites arican Indian, e, etc. ite //industry  rnment  Zip Code)  Town, State  Maryland ome, F/A.
	cate be executed // // // // // // // // // // // // //	dical Examiner	23a. Parl1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consider.)  Necrotizi  Due to (or as a consider.)  Necrotizi  Due to (or as a consider.)	ed Gas equence of): ystem cquerce of): Lng Sm	tric Ulo Organ Fa	cer ailure	or respiratory and	est,	Approximate Interval Between Onset and Death
P.O. Box 68	that the death certificated by the attending pluced by the attending pluced for use as t	by Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	otal death 3 death 5	□Ectopic pregnanc □ Other (specify)		00. Pid.	23d. Date of del Month	Day Year
Division of Vital Records, I	aw requires is been sign 2 should be	Completed by F	Part II. Other significant conditions con	ntributing to death but not r	esuiting in the	underlying cause giv	ven in Part I.	1 ☐ Y 24a. Was a autop perfor	an 24b. Were as prior to med?	to the cause of death?  robably 4  Unknown  utopsy findings available completion of cause of  20 No
ion of Vita	nding Physician: The lath. ath. nr: After this certificate ha	To Be	27. Manner of Death  1 🖎 Natural 5 □ Pending 2 □ Accident investigation	Hospital: 1 X Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury	of 28c. Inju	ner: 4 ☐ Nursing ⊩ ry at		ne) ence 6 □Other (Spe ow injury occurred	cify)
Divis	Ital or Attenvirs after death rel Director: led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify)			City or Tow		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical		sician: To the best of my k ner: On the basis of exami and manner stated.		nvestigation, in my o	opinion, death occu se number	irred at the time, o	date and place, and due	h, Day, Year)
- A			1 Ciaran	ompleted cause of death (It	em 23a) (Type	D6014		TO Md	4	004
Ę.	04   VA Sta	ate	30. Name and address of person who con Aaron Chen, MD	32. Registrar's Sig	nature	treet.,	Dartimo	ie, Ma	21201	
	Regist		MAY 4 2004 Z	toans the	partie!					

**ORIGINAL** 

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 0 0 L 15295 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Janaka Bandara Nakkawita April 27, 2004 8:11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6115 Bradley Boulevard Bethesda Montgomery Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Months Days Hours Min. 1⊠M 2□F None Yrs. 62 Sept. 29, Director 1941 Sri Lanka Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other then "naturel', or Items 23e or 28e-1 ehow eny injury que 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2X No Completed by Funeral Director Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 6115 Bradley Boulevard Sri Lanka 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Asian 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Diplomat Embassy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anula Kuruppu Charles Nakkawita P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rohini Nakkawita/Wife 6115 Bradley Blvd., Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 29, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium Bethesda, Maryland \* 4 □ Donation 5 □ Other (Specify) 2004 Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Metastatic Lung Cancer 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fursasse or injury that initiated events Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) P.O. | Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 🔀 No 1 Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 MR Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2X No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner placed. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD0033293 April 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Ave., #1300, Chevy Chase, Maryland 20815 Frederick P. Smith, M.D. 31. Date filed (Month, Day, Year, APR 3 0 32. Registrar's Signature State 2004 racks Registrar

			1 = For Stete Registrar	State of M	larylan	•	artment			and M			201	<b>)</b> 4	15:	296
	Physici		1. Decedent's Name (First, Middle, La	_	Т						2. Date of De Month	ath Day		ear	3. Time of 6:50	Death a. M
	/Medio Examir		Philip Carroll 1  4a. Facility Name (If not institution, gi	ve street and number	)		,		Location o	of Death	April	4c.	County of			
	Funeral				ge (In yrs. i	last birthday) Yrs.	If Under	kv11 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)		Birthpla Counti	ace (State of	
	Director		578-03-3068  Usual Residence of Decedent  10a. State 10b. County		81	y, Town or Lo	cation				June 25	, 19	ZZ   W		ington	
	e Maryla Ba-f sho	ctor	Maryland Montgo	nery		ckvill	.e								1 ⊠ Yes	
	h with the 23a or 2	ai Directo	10e. Street and Number 1102 Clagett D	rive			10f. Zip	Code 0851				10g. Citi	zen of Wha	at Counti	y?	
920	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, it a Medical Exacil at matter redified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1  Yes 2 If Yes, Give Year or Dates:	?	ì	Was Deceded Yes, special			gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		14. Race - Black, Specify: V	White, e	tc.	
21215-0036	ithin 72 hor ie. ien "naturi Medical	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-4or	5+)	(Give life. I	dent's Usual kind of word DO NOT use	k done di e retired)	urin <b>g m</b> osi		ng	16b. Ki	nd of Busir	ness/Indu	ıstry	
2 2	illed Hygi other	0	10 17. Father's Name (First, Middle, Las	t)		Net	work				(First, Middle,			one (	Compan	у
Maryland	should be nd Mental marked o	To B	Philip Carroll 19a. Informant's Name/Relationship	111111111111	Sr.	19b. Mailir	na Address	(Street a			et Cle		_	ate. Zin (	Code)	
e, Ma	l and 2 steath ar		Jessamine V. Nic				Clag	ett		e, R	ockvill	e, M	D 208	351		
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1   Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Spec		For	emetery, cren rt Lin Cemet	natory or oti COIn	her place	)	Apri			cation - Cit		m, State Mary 1:	and
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once.</u>		21. Signature of Funeral Service vice	nsee	The state of the s	22 F:	. Name and	s J.	Co11	ins	Funeral	L Hor	ne In	c.		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a	NEU s a consequ	n. Do not ent	er the mode	of dying							Approximate Interval Betw Onset and D WC	veen leath
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as												
О. Вох	it the death certific by the attending p tached for use as it	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3	Ectopic pre Other (spe					2	23d. Date o Month		,	ear
ds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death		1	nderlying ca		n in Part I.		23e. Did to		1		cause of de	
al Records,		e Completed	25. Was case referred to medical	1	)				00 Di-		1 Yes	sy road? 20 No	prio	r to comp th?	sy findings a pletion of ca	
Division of Vital	ng Phys ter this neral dii	ToB	examiner?  1 Yes No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpati 28a. Date of Inj (Month, Da	ury	ER/Outpatien 28b. Time of Injury		3c. Injury Work	r: 4□ Nu	rsing Hor	n (Check only o me 5 ☐ Resid 28d. Describe h	lence 6		(Specify)	1.5	
Divis	F Sign	Certification:	3 Suicide 6 Could not determined	288. Place of it	njury - At ho tc. (Specify	ome, farm, str	eet, factory,	office		2	28f. Location (5 City or Tox	Street and yn, State,	d Number (	or Aurai i	Poute Numb	oer,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (	29a. Certifier Check only one) Certifying P	hysicien: To the best miner: On the basis of and manner s	of examinal	wledge, death tion and/or inv	occurred a vestigation,	it the time in my op	e, date and inion, deat	d place, a th occurre	and due to the	cause(s) date and	and manne place, and	er as stat due to t	ted. he cause(s)	
)	To th To th comp	Me	29b. Signature and title of certifier	relle	^		29c.	License	number	518		A Date	e signed (A	Month, Da	$\frac{3y, Year)}{2}$	000
	-01		30. Name and address of person who	21, 1111	death (Item	reter	Print)	PI	1001	+400	PI Re	cle	vre	w,	208	52
	Sta Registi		APR 272	004 Sen	war	19	200	uks	/							

			1 - For State Registrer	State	of Marylar	-	artment of H			•	giene Reg. No	2004	15297
	Physici	an	1. Decedent's Name (First, Middle							2. Date of Dea		004 Year	3. Time of Death
	/Media	cal	BLANCHE W.  4a. Facility Name (If not institution	NIME'			4b. City, Town, or	r Looption		APRIL 2	1		2:20 A
1	Examir	ier	5225 POOKS HILI	. •	inio <del>o</del> r)		BETH		OI Dealii		40.	County of Death MONTG(	OMERY
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h v Year)	9. Birthp Cour	place (State or Foreign
	Director		578-62-7146	1□M 3ॄ□F	90	Yrs.	Months Days	Hours		JANUARY	7,	1914 WAS	SHINGTON, DC
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation					1	Od. Inside City Limits
	Many B-f sh	tor	MARYLAND MONTO	GOMERY			BETHESD	A.					1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number		100		10f. Zip Code	0.00	11		-	en of What Cour	ntry?
	s 23a	rai	5225 POOKS HILI			10 10		208			U.S.		
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show clical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	Armed F	2 (XNo ive		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2∑No	Ispanic Ori In, Mexicar Specify:	n, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Americ Black, White, Specify: WH	etc.
5-0	72 hc	eted	15. Deceden (Specify only higher		)	(Give	dent's Usual Occupa	durina mos	t of work	ing	16b. Kin	d of Business/In	dustry
121	S _ 30	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use retired HYSICIAN	1)				MEDIO	CAT.
<b>d</b> 2	e filed withi Il Hygiene. other than vant, the M		17. Father's Name (First, Middle,		T	· ·	IIISICIAN	18. Mothe	er's Name	e (First, Middle,	Maiden S		
<u>ılan</u>		To Be	LOUIS WIDOME							KATE F	PEARS	ON	
Maryland	and and and		19a. Informant's Name/Relations	hip (Type, Print)			ng Address (Street a				-		Code)
di.	Health Health tem 27 i		DR. ALLEN A. N	IMETZ-SON		_	SPLIT OAK sition (Name of	DRIV		BETHESDA			20817
Jor	nt of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		State	cemetery, crei	natory or other plac			1		ation - City or To	
Baltimore,	permit. Pages 1 Department of H Important: if Ite any injuryor of		<ul><li>4 □ Donation 5 □ Other (S</li><li>21. Signature of Funeral Service</li></ul>		ВЕТ	- 22	OM CONG.  2. Name and Addres	s of Facilit	tv				GHTS, MD
Ba	Dep Imp		> (VIII RIO			ED	WARD SAGE 91 ROCKVI	L FUN	(ERAI				ND 20852
			23a. Part . Enter the disease, or shock, or her it failure. List	mplications that only one cause on	caused the dea								Approximate Interval Between
H	Physician	6	Immediate Cause (Final disease or condition				MALIGNAN						Onset and Death  1 YEAR
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):							
		er	Sequentially list conditions, if any, leading to immediate	b. <u>Üue to</u>	(or as a consec	quanica of):							
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
, 00	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to	(or as a consec	quence of);							
68760,	icate to physic	dicat		d.								_	
.O. Box 6	that the death certifi ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	itcome of pregn birth 2 ☐ Feta nant at time of c nown	aldeath 3⊑	Ectopic pregnancy Other (specify)				20	3d. Date of delive Month	ny Day Year
S, P.	requires that the een signed by th hould be detache	by Ph	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco us	e contribute to th	e cause of death?
ords	w require been sig should b									1□Y	es 2 🛭	INo 3 ☐ Prob	ably 4 Unknown
Vital Record	The law ate has b page 2 si	Completed								24a. Was a autop: perfor 1 Yes	sy	24b. Were autoportion to condeath?	osy findings available inpletion of cause of
Vita	Phyaician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only or			
ō		n; To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date	Inpatient 2	28b. Time of	28c. Injury	at		ne 5½ Resid 28d. Describe h		Other (Specify occurred	")
ion	Attending F r death. actor: After by the funer	atio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig	gation	nth, Day Year)	Injury	Work M 1□	r Yes 2 ☐ !	No				
Division	l or Atten after deat Diractor: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 288. Place	e of Injury - At h ling, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, office		1	28f. Location (S City or Tow	treet and n, State)	Number or Rura	Route Number,
_	spital ours leral filled	ai Ce	29a. Certifier TX Certifyin	g Physicien: To th	e best of my kno	owledge, death	occurred at the tim	ie, date an	d place, a	and due to the c	ause(s) a	ind manner as st	ated.
	To the Hos within 24 h To the Fun completely	edicai	(Check only 2 Medical one)	Examiner: On the tand mar	pasis of examina nner stated.	ation and/or inv			th occurre	ed at the time, o	late and p	place, and due to	the cause(s)
	To the Howithin 24 To the Fucomplete	Σ	29b. Signature and title of contifier	800	and Do	ma	29c. License	number 3554				signed (Month, L	
	vs		20 North		7	7 / / / /		•		A	LVTF	28, 200	+
			DR. JOHN YERG,		Se of death (Iter NECTICU'	n 23a) (Type, T AVENU	Print) JE, #1170	, NW,	WAS	HINGTON	, D.	2001	6
	Sta Registr		31. Date filed (Month, Day, Year) APR 3 0	2004 32. F	Registrar's Signa	ature &	Spark						

NIMETZ, BLANCHE

Thomas C. O'Donnell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-2917 DOS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** THOMAS CRAIG O'DONNELL 29, 2004 April /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 936 Kimberly Way Stevensville Queen Anne's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**∏** M 2□ F Months Days Hours Min. Yrs. 215-62-0901 50 Director JAN. 15,1954 MARYLAND Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits or then "naturel", or Items 23a or 28a-f show the Medical Expriner must be notified at Director MD QUEEN ANNE'S **STEVENSVILLE** 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 936 KIMBERLY WAY 21666 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 ☐ No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT 12 -0-CARPENTER other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fi. Health and Mental H em 27 Is marked oth Be THOMAS VERNON O'DONNELL 2 EVELENE BICKFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 Is any injury or other tret once. DIXIE LEE REICHEL/SISTER 936 KIMBERLY WAY, STEVENSVILLE, MD 21666 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State \* 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 05/01/2004 STEVENSVILLE, MD 22. Name and Address of Facility 21. Signature of Puneral Service, License FFLLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Drowniud resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit certificate be executed Due to (or as a consequence of): 68760 Physician/Medical as Box IF FEMALE asu sesu 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day P.0.

by be

þ Completed page cate Be 2 this Certification: After Hospital or Attending death. Director: 24 hours a

Records,

of Vital

Division

4 Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a, Was an 1 Yes 2 No

111 Penn Street, Baltimore, Maryland 21201

24b. Were autopsy findings available prior to completion of cause of death?

1 No

Year

859

1 XYes 2 □ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 State (Specify) at scene 28d. Describe how injury occurred

Deceased frounce

281. Location (Street and Number or Aural Rouse Number, City or Town, State) 936 Kim herry way Stephens VIIIE, MD 21666 Stevensville, MD

29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 22 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

29b. Signature a

OCME

29d. Date signed (Month, Day, Year)

April 30, 2004

State Registrar

Medical

31. Date filed (Month

5 Pending

investigation

6 ☐ Could not be

25. Was case referred to medical examiner?

1 Yes 2 □ No

27. Manner of Death

1 Natural

3 Suicide

2 Accident

4 \ Homicide

trar's Signature 32. Reg

of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year) Found 4-Z9-04 8:50 AM

within 2 To the

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLIAM WESLEY PEAKER, SR. APRTL 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE 8. Date of Birth Month, Day, Year) NOV 1, 1926 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours Min. 1 ☑ M 2 ☐ F 77 219-14-0419 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar mant be notified at Maryland Harford Director Belcamp 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1123 Belcamp Garth 21017 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Š 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker City of Aberdeen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fill nt of Health and Mental H: :: If item 27 Is marked oth Samuel Peaker Geraldine Beasley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Idella Peaker / daughter 1003 Crimson Tree Way, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Once. injury or John Wesley U. M. Cem ' 4 ☐ Donation 5 ☐ Other (Specify) 5/4/04 Abingdon, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. disa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit actor de Physician/Medicai IF FEMALE f yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autoosy 1 ☐ Yes o the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes 2 No Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

10:50 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

3 Trobably 4 □Unknown

2□ No

Year

1 ☐ Yes 2 X No

2004

USA

HARFORD

Maryland

within 24 hours a To the Funeral D

Medical

State

Registrar

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day,

and address of person

MAY

Year)

2004

29a. Certifier (Check only one)

Sparke

who completed cause of death (Item 28a) (Type, Print)

32. Registrar's Sig

29c. License number

		•	For Stete Registrar	State of Maryland	d / Depa <i>Cei</i>	irtment of F tificate of	lealth and I Death	Mental Hygie 		4 1530
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Margaret R	owlard	Pack			2. Date of Death Month	Day Yea	04 00:20 N
	Examir		11441	iorial Hospito			r Location of Death  de Grad  if Under 24 Hrs.	e l	4c. County of De	rol
	Funeral Director		5. Social Security Number  218-46-4989  Usual Residence of Decedent	7. Age ( <i>lin yrs. la</i> 51	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye May 14,	1952 9. E	Birthplace (State or Foreig Country) Maryland
	after death with the Maryland or items 23a or 28a-1 show miner must be notified at	ector	10a. State 10b. County  Maryland Harfo		Town or Lo	Havre	de Grace	100	. Citizen of What	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with t	ai Dir	10e. Street and Number 981 Chesapeake Dri	ive		10f. Zîp Code	21078	Tog.		S.A.
920	72 hours after death with the Maryland natural', or items 23a or 28a-1 show acal Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. White
21215-0036	c .	ieted	15. Decedent's Educ (Specify only highest grade		16a. Deceo (Give	lent's Usual Occup kind of work done	ation during most of wor	rking 16t	b. Kind of Busines	ss/Industry
212	filed within Hygiene.  other than	Completed	Elementary/Secondary (0-12) Twelve Years	College (1-4or 5+)		Never Emp	oloyed			Employed
and	d be fill and the ced office over	To Be	17. Father's Name (First, Middle, Last)  Wallace M.	Rowland, II				ne <i>(First, Middle, M</i> ai Mary Wa	<i>aen sum</i> am <i>e)</i> rrington	1
Maryland	ges 1 and 2 should be filed within to of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, If the Merchants and the marked other traumatic event.	Ĕ	19a. Informant's Name/Relationship (Type Wallace M. Rowland	oe, Print)		•	and Number or Ru	ıral Route Number, C	ity or Town, State	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R. 1 ☐ Donation 5 ☐ Other (Specify)	Billoval Itulii State		sition (Name of natory or other place s & Co., In			st Chester	or Town, State , Pennsylvania
Balt	permit. Page Department Important: Il any injury o		21. Signature of Funeral Service Li ensa	TO MA DEST	L	erryvill	tterson & e. Marvla	Son Fune	3-0766	, P.A.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		mon		ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
68760,	ificate be executed physician and as the burial-transit	edicai Examiner	Sequentially list conditions, the product of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a consequence to (or as a consequence)						
.O. Box 68	ne death certif the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of o	delivery Day Year
<u>α</u>	ires tha signed d be de	þ	Part II. Other significant conditions con	tributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	./	to the cause of death?  Probably 4 Unknown
I Reco	The law ate has b page 2 sl	Completed						24a. Was an autopsy performed	death	autopsy findings available o completion of cause of ? es 2 \sum No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	ospital:		Oth	00	ath (Check only one)	- 50: 45	
Division of Vital Records,	ding Fune	Certification: To	27. Manner of Death 1 Watural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury	28c. Injur Wor M 1	4 Li Nuising F	ome 5 Residence 28d. Describe how i	injury occurred	Rural Route Number,
Div	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		4 Homicide determined	building, etc. (Specify,	)		ne, date and place	City or Town, S	State)	
	he Hos in 24 ht he Fun pletely	Medical	(Check only 2 Medicel Exemir one)	ner: On the basis of examinati and manner stated.	on and/or in	estigation, in my o	pinion, death occu	rred at the time, date	and place, and d	ue to the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier  Lucy	M.D		29c. Licens	5 A 9 0 4	29d.	Date signed (Mo	
	3		30. Name and address of person who co		23a) (Type,	Print)	race k	1D 21070	f	

State Registrar 31. Date filed (Month, Day, Year)
MAY 4 2004

32. Registrar's Signature

Packard, Margarct 2

# aret Lee Portzen

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
ior.	State of Maryland / Department of Health and Mental Hygiene

15301 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2004 Month **Physician** Мау 10:45A M Margaret Lee Portzen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner La Plata

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Jan. 24, 15 Charles Civista Medical Center Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 10 M X0 F 1932 Mary Tand 72 217-28=8749 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or Items 23a or 28a-f ahow or other traumatic avent, the Mudical Examinar must be notified at 1 ☐ Yes XXNo White Plains Completed by Funeral Director Maryland | Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20695 3735 Middletown Road 12. Was Decedent Ever in U.S. Armed Forcee? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 💢 No Specify: Specify: 3 X Widowed 4 ☐ Divorced natural', 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Paving Company Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be Margaret Blondell Potter Mental and Mental James Gibbons Hammett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 2102 Country Pines Ct., Waldorf, MD 20601 Sandy Buchanan - Daughter 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date St. Peter's Ch. Cemetery 5-04 Waldorf, MD 21. Signature of Funeral Service Licensee Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 MQ1246 A. Wilson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic 0 42953 **Physician** disease or condition resulting in death) /Medical Examiner Lardismy Sauentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 DNo 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပို (his 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D - 3342630. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jenkins, MD 111 La Grange Avenue, La Plata, Maryland 20646 Larry 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 25, 2004 10:00A April George Thornton Parezo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** 69 20, 1934 Washington, Director 579-48-4934 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County in than "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20874 United States 20119 Waterside Drive Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 le marked other than "natural", or Items 23s
any injury or other traumatic event, the Medical Examilier in ust
once. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1952— Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) Self-Employed Master Electrician 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jane Thornton 2 George E. Parezo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20119 Waterside Drive, Germantown, Maryland 20874 Molly M. Parezo/Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery April 27, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State rium, Inc. | 2004 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 4 □ Donation 5 □ Other (Specify) Crematorium, Inc. 21. Signature of Funeral Service Lice see M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YINUTE monary Physician /Medical Due to (or as a consequence of): throm bosis **Examiner** Dec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine UND burial-transit Due to (or as a consequence of): Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COROWARY ARTERY DISEASE 23e. Did tobacco use contribute to the cause of death? Records, CORONARY 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 🗆 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. D. te of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of carrier D46364 APRIL 25,2004 211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11/25 ROUNILUE PIKE # 205, KOUNILUE, MD 2085 SOICOL SICY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 8 2004 sacks Denera Registrar

DHMH 17 Rev 1/2001

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2		Decedent's Name (First, Middle	, Last)								Date of De. Month	ath Day	, ,	Year	3. Time of De	eath
Physic		Therese Phili	ope P	herr	e-Loui	is					April	25		004	6:44	Рм
/Med Exami		4a. Facility Name (If not institution					4b. Cit	y, Town, or	Location of Dea		1	4c.	County o	Death		
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Funeral		5. Social Security Number	6. Sex		7. Age (In )	yrs. last birthday)	If Und	er 1 Year	If Under 24 Hrs	s. 8.	Date of Bir (Month, Da	th	TUTLE	9. Birthpl Coun	ace (State or F	oreign
Director		099-48-5609	1 🗆 M	2 <b>∏</b> F	70	Yrs.	Month:	Days	Hours Min		5v.3		3	Hai		
70		Usual Residence of Decedent														
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should and Men s marke umarke	2	Joseph Philip							Vierge						_777	
and and ls m		19a. Informant's Name/Relations							and Number or F							
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parmit. Pages 1 and 2 should by permit. Pages 1 and 2 should by Department of Health and Menia Importent: If them 27 is marked any injury or other treumatite and once.		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Rem	oval from	n State	b. Place of Dispo cemetery, cre Gate_of	natory o	ame of rother plac	e) Ma	y 1		20c. Lo	ocation - C	ity or To	wn, State	
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mit.		21. Signature of Funeral Service	Licensee	_		$\mathbf{F}_{1}^{2}$	2. Name	and Addres	s of Facility Collins	Fir						
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Physician		Immediate Cause (Final													Onset and Dea	ath
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The COTIGS, F.O. DOX 00/00,  The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c.		utcome of pro		7						23d. Date	of delive	ry	
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INISION I or Attending after death. Director: Afte	Certification:	4 Homicide determ	ined	buil	ding, etc. (S	pecify)	reel, raci	ory, ornice		201.	City or To			Oi iioia	THOUSE HEADE	,
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To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Med	one) 29b. Signature and title of certifie	ır	ariu ma	inner stated.			29c. License	e number			29d. Da	te signed	(Month.	Day, Year)	
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DHMH 17 Rev 1/2001

		•	For State Registrar	State of Man	yland / D	epartme Certifica	nt of He te of D	ealth an Death	d Mental H	lygiene Reg. No.	2004	15304
	MS		Decedent's Name (First, Middle, Last)						2. Date of Month	Death		3. Time of Death
	Physicia /Medic		Elmer	Plate	er				April	Day 24		04 6:15PM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, or	Location of D	eath	4c.	County of Deeth	
			Kensington Nursi				ensing				ontgomer	•
	Funeral Director		5. Social Security Number 578–20–5087	7. Age (//	n yrs. last birth	rs. If Und Month		Hours N	Hrs. 8. Date of Month, July	Dav Yearl	9. Birtt Col Wash	nplace (State or Foreign unity) nington, DC
	D		Usual Residence of Decedent  10a, State 10b, County	11	Oc. City, Town	or Location						10d. Inside City Limits
	aryla shov	_					_					1 X Yes 2 No
	Ne M	ecto	Maryland Montgome	ery	pirver	Sprin	Zip Code			10g Citi	izen of What Co	untry?
	Ma or	Funeral Director	2200 Evans Drive				20902	2		_	ited Sta	
	death ms 2:	era	11. Marital Status	12. Was Oecedent Eve	er in U.S.	13. Was Dec	edent of His	panic Origin	? (Specify Yes or	No-	14. Race - Amer	
3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Menal Hygiene. Department of Heatile and Menal Hygiene. Important: If then 27 is marked other than "natural", or terms 23a or 28a-f show eny injury or other traumatic event, If a Meulcal Evantment has notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ZYes 2 ☐ No If Yes, Give Year or Dates:	1941- 1943		Mo No	Specify:	uerto Rican, etc.)		Black, White Afro-Ame	
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ע	1 and Health Iem 27		20a. Method of Disposition	(daughter)	20b. Place of	Disposition (A	lame of	-	Date	_	ocation - City or	
altilligo	Pages nent of I int: If it		1 Burial 2 □ Cremation 3 □ F  1 4 □ Donation 5 □ Other (Specify)			v, crematory o 19 Memo		" 4.	/30/04	Land	dover, M	<b>I</b> D
	permit. Departm Importa eny inju		21. Signature of Funeral Service Licens	g <sub>i</sub>		22. Name	and Addres	s of Facility	McGuire	Fune	ral Serv	
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1	Physician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediete Cause (Final disease or condition	ications that caused the ne cause on each line.		ot enter the m	ode of dying	, such as car	diac or respirator	y arrest,		Approximate Interval Between Onset and Death
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7	hat the d by t letach	<b>Q</b>	9 Unknown  Part II. Other significent conditions co	ntributing to death but i	not resulting in	the underlying	n cause give	n in Part I	23e. D	id tobacco (	use contribute to	the cause of death?
Records,	requires that the reen signed by th hould be detache	ed by	Chronic Renal F						1-	∐Yes 2	□No 3□Pr	obably Xaunknown
ပ္သ	law re as bee 2 sho	Completed	Severe Hyperten	sion					24a. W	as an utopsy	24b. Were au	topsy findings available completion of cause of
_	sician: The law certificate has b irector, page 2 s	Com							pe 1 ☐ Ye	erformed? s 2 X No	death? 1 ☐ Yes	2□ No
Vitai	ysiclan: is certific director,	Be (	25. Was case referred to medical examiner?				To		Death (Check on	ly one)		
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UIVISION	i or A after Direct	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	,	,		City or	Town, State	)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C	(Check only 2 Medical Exam	rsician: To the best of iner: On the basis of ex	xamination and	, death occurr d/or investigati	ed at the tim	e, date and p	place, and due to to occurred at the time	he cause(s ne, date and	) and manner as d place, and due	stated. to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner state	u.	1	29c. License	number		29d. Da	te signed (Monti	h, Day, Year)
	\ ₹ ¥ ₹ 8		19/10				D 323				il 27, 2	
	441		30 Name and address of person who c	ompleted cause of dea	th (item 23a) (	Type, Print)						
	P.		SK Gupta, M.D.	9801 Georg			er Sp	ring,	MD 2090	2		
	Sta	ate	31. Date filed (Month, Day, Year) APR 2 8 200	32. Registrar	s Signature	li 1	/					
	Regist	rar	LILLY 00 701	14 Janes	/-	1 11	200 10	1				

			For State Registrar	Stat	te of Ma	arylan	d / Depa <i>Cei</i>	artmei rtifica	nt of H	ealth a Death	and M	ental F	lygier Reg. N		04	15	305
	* * * . *	4	1. Decedent's Name (First, Middle,	Last)								2. Date of Month		ay	Year	3. Time of	f Death
	Physici /Medic		Gloria Cristir	a Plaz	za-Fue	ntes						April	25		04	4:25	ам
	Examin		4a. Facility Name (If not institution,	give street a	nd number)			,		Location o			4	lc. County			
100		9		Hospit						Spri			2.11		gome		
	Funeral			5. Sex 1 □ M 2 1			last birthday) Yrs.	Months	Days	If Under :	Min.	8. Date of (Month,	Day, Yea	(r)	Cou		or Foreign
No.	Director		577-78-3599 Usual Residence of Decedent			58	113.					May 2	3, 19	145	COL	ombia	
	and		10a. State 10b. County			10c. Cit	y, Town or Lo	cation								10d. Inside C	ity Limits
	Mary	ō	Manual on a Manual	0000		Т.	Bethes	10							İ	1 € Yes	2 🗌 No
	the 1283	rec	Maryland Montg  10e. Street and Number	omery			Jeches		p Code				10g. (	Citizen of \	What Cou	ntry?	
	38 of	by Funeral Director	5225 Pooks Hi	11 Roa	d #1	307-9	3	2	0814				ī	JSA			
	ms 2	era	11. Marital Status	12. Wa	s Decedent	Ever in U		_		spanic Orig	gin? (Spe	ecify Yes or Rican, etc.)		14. Rac	e - Ameri	ican Indian,	
ထ	or the	Ē	1 ☐ Never Married 2 ☐ Marrie	d 1 □	ned Forces? Yes 2 ∰ es, Give							mbian			Whi		
8	ours :	l by	3 ☐ Widowed 4 ☑ Divorced		ar or Dates:			122 103	20110	opecity.		mb ran		Specify	,		
21215-0036	72 hours after death with the Maryland 'naturet', or Items 23s or 28s-f show dical Examirat rest ke notified at	Completed	15. Decedent's (Specify only highest	Education grade comp	leted)		16a. Dece (Give	kind of w	ork done d	uring most	t of worki	ng	16b.	Kind of B	usines <b>s/I</b> r	ndustry	
21	dthin	Id I	Elementary/Secondary (0-12)	Col	lege (1-4or	5+)			ise retired,	,			n:		- 1 24		
2	tygier tygier ther ti		17. Father's Name (First, Middle, L	actl	4		Acc	ounta	int	18 Mothe	ar's Name	(First, Mid				anagem	ent
ng	be fi	Be	·	a51/							_	ientes		or Damar	.07		
25	d Mer nark natic	Jo	Lazaro Plaza  19a. Informant's Name/Relationsh	in (Tuna Pri	nt)		19h Maili	na Addre	c (Street a	Mery	<u></u>	i Route Nu		or Town	State Zi	n Code)	
Maryland	12 st h and 7 is n traur																hin
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show minjoury or other traumatic event, the Mudical Examinet mant to notified at Once.		Amalia Plaza-Al	varez/	Niec	20b. F	Place of Dispo	sition (N	me of			A L.				Colom own, State	DIA_
20	nt of or or or or or or or	,	1 ☐ Burial 2 🖾 Cremation		I from State		cemetery, cre				Ap	ril 27 2004	,	1	1	77.4	dad a
Baltimore,	artme ortani njun)		* 4 □Donation 5 □ Other (Sp 21. Signature of Inneral Service □		1	Me	tropol:									, Virg	THIA
Ba	Depa Impo eny ir			2	/		F	ranc	ls J.	Coll	ins	Funer	al H	ome I	nc.	g, MD	20001
			23a. Part1. Enter the disease, or o	complications	that cose	d the coat	h. Do not en	ter the mo	ide of dying	g, such as	cardiac o	or respirator	y arrest,	VEL	Tri	Approxima Interval Be	te
	.6		shock, or heart failure. List of Immediete Cause (Final	nly one caus	se on e.ch i	ine.	)									Onset and	Death
	Physician /Medical		disease or condition resulting in death)	a.Res	spirat Oue to (or as	ory	Arrest	_								19 Min	utes
3	Examiner															Days	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. 134	Due to (or as	a consec	uence of):										
	outed nd ransit	Examiner	that initiated events		lon Ca											Months	S
o,	be executician and burial-tran	EX	resulting in death) Last	C	Due to (or as	a consec	quence of):										
68760,	tate be executed by sician and the burial-transit	Icai	3	d													
39	death certificate e attending phys id for use as the	Med	IF FEMALE:														
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	1	es, outcome Live birth	2 Feta	al death 3[		pregnancy						te of deliv onth	,	Year
0.	the deay the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		]Pregnant a ]Unknown	it time of c	death 5	Other (	ъреспу) <sub>—</sub>				-				
<u>α</u>	that the ded by the detached		Part II. Other significant conditio	ns contributir	ng to death i	but not res	sulting in the u	ınderlying	cause give	en in Part I		23e. D	id tobacc	o use cont	ribute to	the cause of	death?
Records,	8 G 9	d by	•									1	☐ Yes	2 <del>√</del> 2 No	3 Pro	bably 4 🗌	Unknown
Ö	2 9 5	ete		7	-							24a. W	Mas an	24h	Were aut	opsy findings	available
Rec	e la has	Completed										a	utopsy erformed	?	prior to co death?	ompletion of	cause of
a	icien: Th certificate ector, pag	_	25. Was case referred to medical	-13						00 01-04	- of Door	1 Ye		No	1 ∐ Yes	2 No	
of Vital		o Be	examiner?  1 Yes 2 No	Hospita	l: 1 ☑ Inpati	ent 2	]ER/Outpatie	nt 3 🗍 [	Othe	00		n <i>(Check on</i> me 5∐R		6 MOth	or (Sner	ihi)	
of		<b> -</b>	27. Manner of Death	28a	. Date of Inj	ury	28b. Time o		28c. Injun Work			28d. Descri					
lon	를 구 등 글	atio	1 XNatural 5 Pending 2 Accident investig		(Month, D	ay rear)	Injury	М		Yes 2	No						
Division	Attendi	iţi	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		. Place of In	ijury - At h	ome, farm, st	reet, facto	ory, office				n (Street Town, St		er or Rui	rai Route Nur	nber,
Ö	s afte	Certification:	1 10111000		oundary, o	10. (0)	·//										
	Hospitel 14 hours a Funeral I		29a. Certifier 1 Certifyin	Physician:	To the bes	t of my kn	owledge, dea	th occurre	d at the tim	ne, date ar	nd place, ath occur	and due to	the cause	(s) and ma	anner as	stated. to the cause(	s)
	the the	Medical	one)		nd manner s												
	To T To I	2	29b. Signature and title of certifier	1 1 0	9			2	9c. License	3533	6		290.	Jate signe		, Day, Year)	
	(0		I bleeva f	. Shap	eller r	3			US		Ψ		Ap	ril	25,	2004	
			30. Name and address of person						. + A	00	Vac	odnat	on 1	AD 30	80=		
			Deena J. Shap	ro M.	32. Regist		Conne	B			Ken	stugt	O11, 1	ט איני	073		
	St Regist	ate rar	APR 28	2004		rapa/	19	10	ands	f.							

		•	For State Registrar	State	of Maryla	nd / Depa	artment of H	lealth an Death	d Mental Hy	giene 0	04	15306
			Decedent's Name (First, Middle	le, Last)					2. Date of De	eath		3. Time of Death
	Physicia		Margery S. Po	11ack					Apri1	24, 2004	Year 4	8:00 PM
	/Medic Examin		4a. Facility Name (If not institution		number)		4b. City, Town, or	Location of D		4c. County		
ı	LAGITIT		7512 Holiday 7	Terrace			Bethesd	а		Montgo	mers	7
	Funeral	-	5. Social Security Number	6. Sex	7. Age (In yr.	s. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bi	rth	9. Birthp	lace (State or Foreign
	Director		578-32-8863	1□M 2ĂF	86	6 Yrs.	Months Days	Hours N	Feb. 1	5, 1918	Cour. M <b>in</b> i	nesota
	p ,	Ì	Usual Residence of Decedent  10a. State 10b. County		100 (	City, Town or Lo	tion				1	0d. Inside City Limits
	anyla shov	_	10a. State 10b. County				Cation				- [	1 ☐ Yes 2 🕱 No
	he M	Directo	Maryland   Montg	omery	Ве	ethesda	100 7:- 0-1-			10g. Citizen of V		
	with t	Ö	10e. Street and Number				10f. Zip Code					
	eath	era	7512 Holiday T		ecedent Ever in	IIS 13	20817	isnanic Origin	? (Specify Yes or N	United		es Indian,
	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or Items 23a or 28e-f show ent, the Medical Evaniner must be notified at	Funeral	1 ☐ Never Married 2 ☐ Marri	Armed	Forces?	0.0.	f Yes, specify Cuba	n, Mexican, P	uerto Rican, etc.)		k, White,	
99	urs af	by	3 ₩idowed 4 Divorced	If Voc I			1 ☐ Yes 2 🎇 No	Specify:		Specify	Whi	te
Maryland 21215-0036	2 hou	Completed	15. Deceden	nt's Education	-1)	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu		
2	thin 7 9.	ple	(Specify only highe: Elementary/Secondary (0-12)		e (1-4or 5+)	life.	kind of work done of DO NOT use retired	dunng most or d)	working			
7	ad wit	Con		2		Secr	etary			Hospit	ality	У
p	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle	a, <i>Maiden Suma</i> m	Θ)	
<u>y</u> la	Ment Ment Brke	၉	William Alphon	so Savag	e				e Ann Dev			
a	2 sho and Is m		19a. Informant's Name/Relations						r Rural Route Numb			
	and lealth m 27		Ross Pollack/S	on	200			ark La	ne, Charl			9412
O	F ite		20a. Method of Disposition  1  Burial 2 Cremation	3 Removal fro	_	cemetery, crei ontgome	sition (Name of natory or other place	(e) A	pril 27,	20c. Location -	City or 10	wn, State
≣	Pa tmen tent: jury		`4 □ Donation 5 □ Other (S		Ci	remator:	ium. Inc.		004	Bethesd		
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or wher treumetic event, the Madical Examiner must be rotified at once.		21. Signature of Funeral Service	Licensee	1. MOO	$\begin{array}{c c} & \begin{array}{c} B^2 \\ B \\ B \end{array}$	Name and Addre ethesda-C ethesda.	ss of Facility Thevy Cl Marvla	Robert A. hase, Inc nd 20814	. 7557 w -3501	y Fui iscoi	neral Home/ nsin Avenue
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that	at caused the de							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			enosis.	End Sta	P				Onset and Death
	/Medical		resulting in death)		to (or as a cons		HIII Deag					_
П	Examiner		Sequentially list conditions,				ar Heart	Diseas	e			
	p =	iner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	tu (ur as a consi	equence of):						
	ecute and trans	Examiner	that initiated events resulting in death) Last	c	to (or as a conse							
8760,	oe ex cian a	E		D09	to (or as a cons	aquance on.						
87	The law requires that the death certificate be executed attending physician and bage 2 should be detached for use as the burial-transit	dicat		d								
9 X	death certifica attending ph d for use as t	/Me	IF FEMALE:	23c. If ves.	outcome of preg	inancy				22d Date	e of delive	
Box	that the death certined by the attending	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	e birth 2 Fe	etal death 3	Ectopic pregnancy Other (specify)	,		Mor		Day Year
o.	the di	ysic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	nU□e		30						
Δ.	that ned by deta	/Ph	Part II. Other significant condition	ons contributing to	o death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contr	ibute to th	e cause of death?
ds,	uires l signe Id be	q p	Hypertension	1					1 🗆	Yes 2∑No	3 🗌 Prob	ably 4 Unknown
Record	w requir been si should	Completed	Degenerative	Toint D	icasca				24a. Was	an 24b. V	Vere auto	psy findings available
	The fav	m		. JOINE D	Isease				auto	ppsy ormed? d	rior to cor eath?	npletion of cause of
Vita		e Co	Osteopenia 25. Was case referred to medica	al				Of Blace of	1 Yes		Yes	2 No
₹		o B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	☐ Inpatient 2	☐ ER/Outpatier	at 3 DOA Oth	or	Death (Check only		or (Specifi	4)
Division of	ig Physiter this neral di	$\vdash$	27. Manner of Death	28a. Da	ite of Injury	28b. Time o	28c, Injun	v at		how injury occurre		7
<u>o</u>	Attending r death. ector: After	atio	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	ng (Mi igation	fonth, Day Year)	Injury	Wor M 1 □	kr Yes 2 □ No				
V is	Attending Ph or death. ector: After th by the funeral	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 286. Pla	ace of Injury - At	home, farm, str	eet, factory, office			(Street and Number	er or Rura	l Route Number,
٥	s after s after el Direct	Certification:	4   Holmodo	Du	maing, etc. (ope				Only of 70			
	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Afcompletely filled in by the fur	Medical		Exeminer: On the					lace, and due to the occurred at the time,			
	To the vithin 7 To the comple	Me	29b. Signature and title of certific	FO 70. 4. 4	7/-	C 0	29c. Licens	e number		29d. Date signed	(Month,	Day, Year)
)	10		House	VALLI	7 00	MCC	н4583	9		May 26,	200/	4
	(		30. Name and address of person	who completed ca	ause of death (It	em 23a) (Type,				11dy 209	_2005	•
			Gary E. Raffe	1, D.O.	5411 W	est Ced	ar Lane,	#202A,	Bethesda	, Maryla	nd 2	20814-1150
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8		. Registrar's Sig		Sporter					
	91.51		WI 1/ 10 O	LUUT /	W 7 7 7	/-	Sand on Many					

			1 - For State Registra AMEND#23a(b) per		-	artment of F		-	Reg. No. 2 (	004 1530
>	Physici /Medi Examir	cal		reston		4b. City, Town, o	r Location of Deat	April	Day	Year   3. Time of Death   1:44 P   M   Of Death
A SEAR	Funeral Director		Suburban Hospita: 5. Social Security Number 6. Sec. 153–20–6471		t birthday) Yrs.	Bethe If Under 1 Year Months Days	sda If Under 24 Hrs Hours Min.		th y, Year)	9. Birthplece (State or Foreign Country)
	מ	tor	Usual Residence of Decedent   10a. State   10b. County   MD   Montgome	10c. City, T	own or Lo		wille	NOV. 29	7,1925	NY  10d. Inside City Limits 1    ↑
	with the 3a or 28a	Funeral Director	10e. Street and Number 5550 Tuckerman L	ane		10f. Zip Code	20852		10g. Citizen of V	·
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. The Marifuel Examinate to Inditional any injury or other traumatic event. The Marifuel Examinate Item Inditional Annual Conce.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H if Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		e - American Indian, sk, White, etc.
21215-0036	ithin 72 ho ne. han "natur hanlica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give life. l	dent's Usual Occup kind of work done o OO NOT use retired	ation during most of wo d)	rking	16b. Kind of Bu	,
Maryland 21	uld be filed w Aental Hygier rked other th tic event, In	To Be Cor	17. Father's Name (First, Middle, Last)  John F. Kenneal		Н	omemaker	18. Mother's Na	ne (First, Middle,	Own  Maiden Sumam  antmaye	re)
e, Mary	1 and 2 shou Health and N Sm 27 le mai		19a. Informant's Name/Relationship (Ty Kathleen Orr/ Dau 20a. Method of Disposition	ghter	9808	g Address (Street and Montauk	Avenue,		, MD 20	817
Baltimore,	artment of hortant: If its injury or of		1	Gate	of I	sition (Name of natory or other place Heaven . Name and Addres	Apr	<u>i</u> 1 22	Silver	City or Town, State  Spring  e, 10 East Deer
Ba	Per Jeng Suny	6 1	23a. Part1. Enter the disease, or complete	uvee	1	ark Driv	e, Gaith	ersburg,	MD 208	Approximate
8760,	Physician / Medical Examiner physician and physician and the phuar-transil	i Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sauentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent to Connective House to (or as a consequent to Connective House to (or as a consequent to Connective House to (or as a consequent to Connective House to (or as a consequent to Connective House to (or as a consequent to Connective House to (or as a consequent to Connective House to (or as a consequent to Connective House to Connective Hous	ry Syce of): litus ce of): eart ce of):	yndrome Type I s <del>Type II</del>				Interval Between Onset and Death
P.O. Box 687	Attanding Physician: The law requires that the death certificate be executed rideath. sctor: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. Hypoglycemia  33c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death	, ath 3⊑	Ectopic pregnancy			23d. Date Mor	e of delivery hth Day Year
	w requires that I been signed by should be deta	by	Part II. Other significant conditions cor	ntributing to death but not resulting	g in the ur	nderlying cause give	en in Part I.			ibute to the cause of death?  3 Probably 4 Unknown
Division of Vital Records,	ysician: The law re is certificate has bee director, page 2 sho	e Completed	25. Was case referred to medical				ac Plant of Da	24a. Was a autop perfor 1 Yes	med? d 2 No 1	Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2☐ No
j V	hysicie this cert al direct	To Be	examiner? 1 ☐ Yes 2 ☑ No		/Outpatien	The second secon	er: 4 🗆 Nursing H	ome 5 Resid	ence 6 Othe	
ivision	- e = -	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28 28e. Place of Injury - At home building, etc. (Specify)	b. Time of Injury , farm, stre		/ at ⟨? Yes 2 □ No			er or Rural Route Number,
Ω	To the Hospital c within 24 hours at To tha Funaral D completely filled in	Medical Ce	29a. Certifier 1 A Certifying Physical Check only 2 Medical Examinate	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim restigation, in my op	ne, date and place pinion, death occu	, and due to the c	ause(s) and mar date and place, a	nner as stated. Indidue to the cause(s)
,	To the within to the comple	Me	29b. Signature and title of cenifier	`		29c. License D3013		1	29d. Date signed April 21	(Month, Dey, Year)
			30. Name and address of person who co M.Ratta Ghosh, M.D.				l, Rockv	ille, MD	20850	
11	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		Ana Ko		<u> </u>		

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I	Health a	and Mental Hy	giene 200	L 15308
			1. Decedent's Name (First, Middle, Las	)				2. Date of De		3. Time of Death
	Physici /Medi		David Raymo	nd Price	2			Month April	23, 2004	
1	Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of		4c. County of D	
			Suburban Hospital			Betheso	la		Montgom	erv
	Funeral		Social Security Number     6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Date of Bi		Birthplace (State or Foreign Country)
	Director		213-33-0701	XIM ZUF	24 Yrs.			Nov. 1		exas
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Marylar f show	Ö	Maryland Montg	omerv		Bethesda				1 ☐ Yes 2 ☑ No
	r 28e	Funeral Director	10e. Street and Number			10f. Zip Code	•		10g. Citizen of What	
	3a o		7120 Armat Dr.			20817	7			
	death	nera	11. Marital Status	12. Was Decedent E	ever in U.S. 13.			gin? (Specify Yes or No , Puerto Rican, etc.)	U.S.A. 14. Race - A	merican Indian,
9	after or ite	Ī	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X	0			, Puerto Rican, etc.)	Black, W	hite, etc.
93	ours iral',	d b	3 Widowed 4 Divorced	Year or Dates:		1□Yes 2\X\\ No	Ѕреспу:		Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland lat Hyglene. d other then "natural", or items 23a or 28e-1 show event, tre Modical Everting renative rectified at	Completed by	15. Decedent's Edu (Specify only highest grad	ication le <i>completed)</i>	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most	of working	16b. Kind of Busine	ss/Industry
12	withir ane. Ithen	E D	Elementary/Secondary (0-12)	College (1-4or 5-	+) //fe.		od)			
d 2	filled Hygi ther int. I		17. Father's Name (First, Middle, Last)	2		Student	18 Mother	r's Name (First, Middle	Maidan Sumama)	
/lan		To Be	Paul Price					anice Parke		
lan	ts but a	i	19a. Informant's Name/Relationship (T)					r or Rural Route Numb	er, City or Town, State	a, Zip Code)
6	1 and Health Bm 27 ther tr		Paul Price/ Father	<u>-</u>				thesda, MD	20817	
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Importent: If item 27 to eny injury or other tra		20a. Method of Disposition  1 □ Burial 2 ☆ Cremation 3 □ ↑  4 □ Donation 5 □ Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cres Baltimore			pril, 30	20c. Location - City Laurel, MI	
altii	permit. B Departm Importer eny injur		21. Signature of Funeral Service Licens					Joseph Gaw		
ш	40 E 9 9		Mylling CX	07	MU1290 5	130 Wisco	onsin	Ave., NW, N	Washington	, DC 20016
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the cause on each line	the death. Do not ent	er the mode of dyir	ng, such as o	cardiac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Asphy	Ciation					Onset and Death
	/Medical Examiner		resulting in death)		consequence of):					0
		16	Sequentially list conditions,		SION consequence of):					
	ted nsit	nju	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dueno (ci as a	consequence or).					
<u> </u>	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760,	icate be executed physician and s the burial-transit	dlcal		1						
9	tificat ng phy as th	ledi								
Box	eath certific attending p for use as	an/N	200. Was decedent pregnant	3c. If yes, outcome o		Ectopic pregnancy	,		23d. Date of c	lelivery
	the death certifii y the attending p iched for use as	Physiclan/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at ti 9☐Unknown		Other (specify)	·		Month	Day Year
P.0	that the de ed by the detached	Phy	Part II. Other significant conditions col	atributing to doath but	t not rosulting in the		1- 81	20- Bitt		
Records,	Se 20 00	d by	Tarris of the same	imoding to doubt but	Thou resulting in the u	idenying cause giv	on meant.	1 🗆 1	V'	to the cause of death?  Probably 4 □Unknown
50	w require been si should b	Completed						_		
Re	The law cate has page 2 s	E C						24a. Was autop		autopsy findings available completion of cause of
Vital	(0		25. Was case referred to medical				00 51	1 Yes	2 XNo 1 □ Ye	
	Physicien: r this certific ral director,	To Be	exaptiner?	lospital:	t 2 ER/Outpatien	3 DOA Oth		of Death <i>(Check only o</i> sing Home 5 🐧 esid		(f.)
10	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of	28c. Injun	y at		low injury occurred	(ectry)
0	utendin death. ctor: Afi y the fur	atlo	1 □Natural 5 □ Pending 2 □ Accident investigation	Arr, 23,2		a₁M 1□	/	· Hangir	19	
Division of	r Atte	Certification;	3 Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Local n (S City or Tow	et and Number or I	Rural Route Number,
	itel or ret D			hou				7120 Ar,	not Dr. Bi	thesda, MD
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physical Check only one) Medical Examination	ier: On the basis of e	examination and/or inv	occurred at the tin	ne, date and pinion, death	place, and due to the o	cause(s) and manner a	as stated.
	o the ithin 2 the omple	Mec	29b. Signature and title of certifier	and manner state	90.	29c. License			29d. Date signed (Mor	1
)	+ 3 F 8		Patricia Tome	the na	y, mod	D	5 1916	9 1	Apr. 23	2004
•	5		30 Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type, I	Print)	10 /	10 1	1.617	/ /
			Patricia lomsko	Nay, MD, 1	6121 Mor	trose	Rd,	Kockvi	1/E, MD	20852
	Sta Registra		31. Date filed (Month, Day, Year)  APR 2 7 200	32. Registrar	's Signature	han il	,		/	
		-41J	MFR & 1 ZUU	4 June	1	pypours				

DAVID PRICE 4/23/04 ONLO

			1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of F	lealth and Death		iene 20	04	15309
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
Ī	/Media	al	Beulah G. Ramsey			4. O: T			23 <sup>Day</sup> 200		10:10 AM
	Examir	er	4a. Facility Name (If not institution, give s Suburban Hospital	reet and number)		4b. City, Town, o Bethes		eath	4c. County		
	Funeral	-	Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year			Mont	9. Birtho	lace (State or Foreign
	Director		577 <b>-</b> 60 <b>-</b> 3693	M 2 100	Yrs.	Months Days	Hours N	Aug. 9,	1903	Coun	land
	pu 🔭		Usual Residence of Decedent  10a. State 10b. County	10a Cit	/. Town or Lo						
	faryla show	ō			shingt					1	0d. Inside City Limits 1 X Yes 2 □ No
	the N 28e-1	Director	D.C. N/A  10e. Street and Number	We	SIIIIIgu	10f. Zip Code		1	0g. Citizen of V	Vhat Coun	
	3e or	i Di	1213 Crittenden S	treet. N.W.		20011		1.	United		•
	death	Funerai		Was Decedent Ever in U.     Armed Forces?	S. 13. V		ispanic Origin?	(Specify Yes or No- uerto Rican, etc.)	14. Race	e - Americ	an Indian,
õ	or ite	y Fu	1 Never Married 2 Married	1 Tes 2 ANO	I .	Yes 2 No	Specify:	Jerto Hican, etc.)		k, White, o	
9500-612	hours tural',	d by	3 → Widowed 4 □ Divorced	Year or Dates:							
υ Γ	in 72 in af	oiete	15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced (Give i life. D	lent's Usual Occup kind of work done o OO NOT use retired	ation du <i>ring most of</i> t	working	16b. Kind of Bu	siness/Inc	dustry
7 7	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		tor Opera			Federa	al Go	vernment
פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's h	Name (First, Middle, M	Maiden Sumam	е)	
yland	Menta Menta arked	To	Harry Gray				Laura	Hurd			
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumetic event. It a Madical Examinar must be notified at once. 5		19a. Informant's Name/Relationship (Typ					Rural Route Number			Code)
≥ o`	1 and lealth om 27 ther to			(Friend)				., Washing			20011
saltimore,	ages or of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕅 Re	moval from State	metery, crem T1St R	sition (Name of patory or other place eformed	θ)		20c. Location -		
	artme rich		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>	Co	ngrega	tion	4/		liddleto		
g	Depire Impo		) Thombo	y Clartin	7	400 Georg	osia ∆vo	cGuire Fun • N.W., Wa	eral Se	rvic	e .C. 20012
	15-2		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	. Do not ente	or the mode of dying	g, such as card	diac or respiratory arre	est,	л, р	Approximate
	Pnysician <sub>i</sub>		Immediate Cause (Final disease or condition	COKONAR			_				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		1 01	VIJ CB	-) -		-	
	Examiner		Sequentially list conditions. b.								
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequ	ience of):						
	xecut and al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):					-	
8/00,	cate be executed physician and the burial-transit	dicalE			,						
0		ledic	d.								
DOX	w requires that the death certificens been signed by the attending should be detached for use as	Physician/Me	230. Was decedent pregnant	c. If yes, outcome of pregnal		Ectopic pregnancy			23d. Date	of deliver	y
	e deal	sicie	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnant at time of de		Other (specify)			Mon	th I	Day Year
г Э	d by the	Phy	9 Unknown							217 (D) / 10 (D) and (D)	
,	The law requires that the ate has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions cont	ributing to death but not resu	iting in the un	derlying cause give	en in Part I.				e cause of death?
ecords,	requ been should	etec						-			
ย	has ge 2 :	Completed	-					24a. Was an autopsy perform	24b. W	/ere autop rior to com eath?	sy findings available ipletion of cause of
VIIAI		e Co	25. Was case referred to medical					1 ☐ Yes 2	<b>≥</b> No 1	Yes 2	2□ No
	ding Physicien: h. After this certific funeral director,	0 0	examiner?	spital: 1 ☐ Inpatient 2 🛣 I	R/Outpatient	3□ DOA Othe	· · ·	Death (Check only one Home 5 Resider		r (Cnasiful	
5	g Ph er thi	L id	27. Manner of Death		28b. Time of Injury	28c. Injury Work	at	28d. Describe ho			
2	endin sath. or: Aff	atic	1 Natural 5 Pending investigation	(Month, Day 1 day)	injury		es 2 □ No				
DIVISION	r Att	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number State)	r or Rural	Route Number,
ב	urs af urs af erel D	O									
	Hosp 24 ho Fund stely f	edicai	29a. Certifier 1 Certifying Physi (Check only 2 Medical Exemine	cien: To the best of my know er: On the basis of examinati and manner stated.	vledge, death on and/or inve	occurred at the time estigation, in my op	e, date and pla inion, death oc	ice, and due to the car curred at the time, da	use(s) and man te and place, ar	ner as sta nd due to t	ted. the cause(s)
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Mec	29b. Signature and title of certifier	and oracou.		29c. License	number	29	d. Date signed	(Month, D	ay, Year)
	4		mall.			7 6	2767		_		
	70		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, P	2-4			04/2	1/	
			H.S. SETHI S	O W EDM	ONSTO	n Daire	# 3	o) Rockv	ILLE	171	0 50825
	Sta Registra		31. Date filed (Month, Day, Year)  APR 2.8 200	32. Registrar's Signat	ure A	down					
		- 1	711 IV & U CUU	R I FREE F	/	The state of the s					

4/23/04 1010

4.1			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of I rtificate of			jiene •g. No. 200	4 15310
	Physici	an	Decedent's Name (First, Middle, La.	•				2. Date of Dea Month	th Day Year	3. Time of Death
	/Media		Richard Charl		n			April	22 2004	10:28 A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give				or Location of Deal	h	4c. County of De	
		A.	Shady Grove Adver		Ital (In yrs. last birthday)	Ro	ckville If Under 24 Hrs	8. Date of Birth	Montgome	
	Funeral Director			□M 2□F	34 Yrs.	Months Days			, Year)	rthplace (State or Foreign Country)
	pu ,		Usual Residence of Decedent		10 02 7					
	anyla shov	-	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits 1 XYes 2 □ No
	the Marylar 28a-f show notified at	ecto	MD Montgome	ery	Gai	thersbur	g	Т.		
	with t	Funeral Director	10e. Street and Number	# <b>r</b> oz		10f. Zip Code	077		0g. Citizen of What 0	•
	s 23	era	333 Russell Avenue	12. Was Decedent E	iver in IIS 13		877		United Sta	
	Item Item	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	0	If Yes, specify Cub	pan, Mexican, Puer	specify Yes or No- to Rican, etc.)	Black, Wh	
336	urs al	by	3 X Widowed 4 □ Divorced	1 ⊠Yes 2 □ N If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
21215-0036	within 72 hours atter death with the Maryland ane then "netural", or Items 23a or 28a-1 show ita Madical Examiliar must bu notified at	Completed	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines	s/Industry
215	hin 7	ple	(Specify only highest gra		life.	kind of work done DO NOT use retire	adring most of wo	rking		
2	ed wil	Con		College (1-4or 5-	Log	istics Of	fficer		CIA	
nd	d oth	Be (	17. Father's Name (First, Middle, Last)					me (First, Middle, I	,	
yla	Men Men marke	2	Charles Walter Re				Eulala	Vonee Es	tep	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural; or items 23a or 28a-1 show any injury or other traumatic event, Ita Madreal Examinar must be notified at anore.	V J	19a. Informant's Name/Relationship (						, City or Town, State,	
e,	1 and Health am 27 ther t	1 8	Randall P.R. Reard	1011/5011	20b. Place of Dispo		wood Cour		arket, MD	
و	Se = 100		1 X Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory`or other pla	I M O TT	10,2004	20c. Location - City o	
Baltimore,	rtmer rtant njury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licer</li> </ul>		Arlingto		Ly		Arlington	, Virginia
Ba	permi Depa Impo	d z	TRACYA Ju	in	<u> </u>	eer rark	DIIVe, G	artherso	ral Home, urg, MD 20	10 East 877
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line a. Pneumoni	a.	er the mode of dyii	ng, such as cardia	or respiratory arre	est,	Approximate Interval Between Onset and Death
No.	Examiner		1		consequence of):	D. 1	D.			3
-		Jer	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying		Obstructi	ve Pulmor	nary Dise	ase		
	death certificate be executed e attending physician and ind for use as the burial-transit	Examiner	that initiated events	c						
,097	e exe		resulting in death) Last	Due to (or as a	consequence of):					
876	ate b hysic the b	licai		d						
x 68	death certificate b attending physic d for use as the b	by Physician/Med	IF FEMALE:	00-14						
Вох	attenc attenc	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death 3	Ectopic pregnancy	у		23d. Date of de Month	Nivery Day Year
Ö	that the de ted by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	ime or death 5L	Other (specify) _				
۵	that t ed by detac	H.	Part II. Other significant conditions c	ontributing to death but	t not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
Records,	o o	d by				, , ,		10		robably 4 Unknown
00	w requir s been si should	lete						24a. Was ar	24b. Were a	utopsy findings available
Be	The lav	Completed						autops	y prior to ned? death?	completion of cause of
Vital		a	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2		s 2🔯 No
$\geq$	8 5	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 🛣 Inpatien	t 2 ER/Outpatier	nt 3 DOA Oth			nce 6 □Other (Spe	ecify)
n of	ding Phy h. After thi tuneral c		27. Manner of Death 1  Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	28c. Injur	ry at	28d. Describe ho		
Division	Attanding r death. actor: After by the tune	Certification:	2 ☐ Accident investigation				Yes 2 □ No			
. <u>Š</u>	l or Attano atter deatt Diractor; I in by the	Ħ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or Fi , State)	ural Route Number,
Ω	urs at rat D									
	To the Hospital or Al within 24 hours atter of To tha Funeral Dirac completely tilled in by	Medical	29a. Certifier  (Check only one)  1 ☑ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of niner: On the basis of and manner state	examination and/or in	n occurred at the tir vestigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)
	11		) Mus		pu	D586	81		April 22	, 2004
1	レベ		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type.					-
			Jude Alexander, M	.D., 9901	Medical Co	enter Dri	ve, Rock	ville, MD	20850	
ă.	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Spork				
	Registr	ar	APR 27 2	JU4	10	Laborar				

			1 - For State Registrar	State of Maryland	d / Depa		lealth and M	lental Hygie	ene 1. No. 2004	15311
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last ANWER J 4a. Fecility Name (If not institution, give Hebrew Home Of	AHAN street and number)	REH		r Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 452-51-3763  Usual Residence of Decedent	х ] м 2⊠F 7. Age (In yrs. la 94	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 0 Ct. 29,	(9.8) 9. Birth Pak	place (State or Foreign Intry)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any igingy or other traumatic event, the Medical Existing Insust he notified at once.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Montg  10e. Street and Number  5901 Montrose  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed.  (Specify only highest grad  Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last) Fazal Husain  19a. Informant's Name/Relationship (TyPari Rehman - Do	Rd. #103  12. Was Decedent Ever in U.S Armed Forces? 1 Yes. 3 2 Mo If Yes. Give Year or Dates: (cation le completed) College (1-4or 5+)  Type, Print) a ughter  Removal from State  Ge 0	16a. Deced (Give) Hon 19b. Mailing 5 9 0 1 ce of Dispos metery, crem Was	I 1 e  10f. Zip Code 2085  Vas Decedent of I-Yes, specify Cubic Pyes 2 No ent's Usual Occupation of Work done NOT use retirection of Work done on NOT use retirection of Montros g Address (Street Montros sition (Name of alroy or other places in Ceme	ispanic Origin? (Span, Mexican, Puerto Specify:  ation during most of workin)  18. Mother's Name Nazeer  Nazeer  and Number or Rura  Se Rd, Ro  et. 4-27	ng 16  (First, Middle, Ma. Begum  I Route Number, Cckville ate 200  A	J. Citizen of What Cou USA  14. Race - Ameri Black, White, Specify: As b. Kind of Business/In	can Indian, etc.  i a n  idustry  c Code)  5 2  cown, State  d .
ds, P.O. Box 68760,	law requires that the death certificate be executed  so been signed by the attending physician and 2 should be detached for use as the buriat-transit	i by Physician/Medical Examiner	23a. Peri 1. Enter the disease, or complishook, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a conseque  Due to (or as a conseque  Due to (or as a conseque  Due to (or as a conseque  Due to (or as a conseque  Li  Live birth 2 Fetal d  Pregnant at time ot dea	nce of):  nce of):  nce of):	Ectopic pregnancy Other (specify)	- £	23e. Did tobacc	23d. Date of delive Month	Day Year e cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requir within 42 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should it.	Medical Certification: To Be Completed	27. Mannerof Death    Natural   5   Pending investigation   3   Suicide   4   Homicide   Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hom building, etc. (Specify)  ician: To the best of my knowler: On the basis of examination and manner stated.	edge, death on and/or inve	M 28c. Injury Work 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e, date and place, an inion, death occurren	24a. Was an autopsy performed 1 Yes 22 (Check only one)  10 Se 5 Residence 3 Residence 3 Residence 3 Residence 3 Residence 4 Residence 5 Residence 5 Residence 5 Residence 5 Residence 6 R	death?  1 Yes  6 G Other (Specify)  njury occurred  and Number or Rural late)  e(s) and manner as sta and place, and due to  Date signed (Month, D	posy findings available included in a cause of several position of several position of several p
	Sta Registr		30. Name and address of person who con the state of the s	→ D. (2 ( Vm)  32. Hegistrar's Signatur	sa) (Type, Pr √ T∠c	SE Ref	ha Rock	cuice m	MILAND	20052

ORIGINAL

DHMH 17 Rev 1/2001

		•	For State Registrar	State o	f Maryla	•	artment of H				iene •g. No.2001	1531	2	
	Physicia		1. Decedent's Name (First, Middle, L	ast)					2.	Date of Dear Month	th Day Year	3. Time of Death		
	/Medic			Wealthy	Mae	Reisin	<u> </u>			pril	24, 2004	6:05 P	<b>Л</b>	
	Examin	er	4a. Facility Name (If not institution, gi		mber)		4b. City, Town, or		of Death		4c. County of Dea	ath		
			Vantage Hous  5. Social Security Number 6.	Sex	7. Age (In vr	s. last birthday)	Colum		24 Hrs. 8.	Date of Birth	Howard	rthplace (State or Foreig	70	
	Funeral Director			1□M 2∏F	95	Yrs.	Months Days	Hours	Min.	(Month, Day,	Year) C	rginia		
	ס		Usual Residence of Decedent								, =====		_	
	arylar show	_	10a. State 10b. County			City, Town or Lo						10d. Inside City Limits		
	28a-f	Director	Maryland Howard  10e. Street and Number			Columbi	.a. 10f. Zip Code				0g. Citizen of What C		_	
	a or		5400 Vantage Po	int Roa	A		21044				United Sta	•		
	Jeath	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of H		igin? (Specify		14. Race - Am	erican Indian,	_	
٥	or Item		1 ☐ Never Married 2 ☐ Married	Armed Fo	2 X No				n, Puerto Ric	an, etc.)	Black, Wh			
2-003e	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show collest Extra little at the netiting at	d by	3 Widowed 4 □ Divorced	If Yes, Gir Year or D	ates:		1 ☐ Yes 2 汉 No	Specify:		-	Specify: W	hite		
	"natu	Completed	15. Decedent's I (Specify only highest g			(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most	t of working		16b. Kind of Busines	s/Industry		
7	within and the Man	т	Elementary/Secondary (0-12)	College (	1-4or 5+)		maker	2/			Own Home			
0	Hyg ther ther	ø	17. Father's Name (First, Middle, Las			Home	maker	18. Mothe	er's Name <i>(F</i>	irst, Middle, I	Maiden Sumame)		_	
land	2 C - 2	OB	Levi Cathell					Ann	ie Mae	Denn	is			
ar	as 1 and 2 should b of Health and Ment item 27 is marked cother traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	an <i>d Numb</i> e	er or Rural R	oute Number	, City or Town, State,	Zip Code)		
, Ma	os 1 and 2 of Health item 27 i		Letitia R. Geige	r / Daug					1, Wil	The second second	urg, Virg			
saitimore,	H iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from	State 20b.	Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	May	1,	20c. Location - City o	r Town, State		
	trant: Pag		`4 □ Donation 5 □ Other (Spec	eity)			morial Park		2004	I	Rockville,	Maryland	_	
ga	permit. Pages 1 Department of H Important: If ite any injury or of		21. Signature of Funderal Service Lice	info	MO1:	305 Ro		iphrey In Aver	Funera nue, be			vy Chase, Inc 814–3501		
			23a. Part I Enter the disease, or conshock, or heart failure. List only	mplications that of your cause on e	aused the de ach line.	ath. Do not ent	er the mode of dyin	ig, such as	cardiac or re	spiratory arr	est,	Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	a th			mentin -	17/2	HEIM	ER'S		years		
	/Medical Examiner		1 Country	Due to	(or as a conse	equence of):		•				V		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a conse	equence of):					-		_	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6										
ĵ	be executed ician and burial-transit		resulting in death) Last	Due to	(or as a conse	equence of):								
0/g	icate be executed physician and s the burial-transit	Ical		d										
٥	ertific ding p	Mec	IF FEMALE:	22a If yes au	loomo et eroa								_	
X Q	death certificate e attending phys d for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?		pirth 2 ☐ Fe piant at time of	tal death 3	Ectopic pregnancy Other (specify)	,			23d. Date of de Month	Day Year		
j.	the de	yslo	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkn		Geath 3C								
7	The law requires that the de te has been signed by the age 2 should be detached		Part II, Other significant conditions	contributing to d	eath but not re	esulting in the u	nderlying cause give	en in Part I.		23e. Did to	pacco use contribute	to the cause of death?		
2	quires in sign	ed by	PNeumin							1 □ Ye	es 2□No 3□F	robably 4 Unknown	ก	
ecords	aw re- is bee 2 sho	ompleted	V							24a. Was a autops	n 24b. Were a	utopsy findings available completion of cause of	0	
Ĭ	The I	mo:								perforr	ned?   death?	s 2 No		
Vital H	ysician: The law is certificate has t director, page 2 s	Bec	25. Was case referred to medical examiner?					26. Place	of Death (C	heck only on				
010	this d	P	1 Yes 2 No			ER/Outpatier		70.00			ence 6 Other (Sp.	ecify)	_	
	fer	lon	27. Manner of Death 1 ANatural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2∐1		. Describe ho	ow injury occurred			
UNISION	Attending or death. ector: After by the fune	flcat	2 Accident investigati 3 Suicide 6 Could not	be as Blace	of Iniury - At	home, farm, str	reet, factory, office	163 2 🗆 1	-	Location (SI	reet and Number or F	Jural Route Number.	-	
2	after after Dire	Certification:	4 ☐ Homicide determine	build	ing, etc. (Spec	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town	n, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C		aminer: On the b							ause(s) and manner a ate and place, and du			
	within 2 To the comple	Mec	29b. Signature and title of Pertifier	and man	514104.		29c. Licens	e number		2	9d. Date signed (Mon	th, Day, Year)		
	->-0		1 600 111	in			5-	3418	168		April 2	6, 2004		
-	W		110	o completed caus	se of death (It	em 23a) (Type,	Print)	Parke	cers	Fol	urbas Mer	6, 2004 29044		
	Sta	te	31. Date filed (Month, Day, Year)	32. F	Registrar's Sig	nature	1		0	/		• /		
	Registr	_	APR 3 0 200	14 50	erra	p ,	sporter							

DHMH 17 Rev 1/2001

			Registrar	State of Ma	aryland / Depa	artment of rtificate of	Health and Death	F	Reg. No.	2004	1531	3
>	Physici /Medic	al	Decedent's Name (First, Middle, Last)     Ruth Lee Layne     A. Facility Name (If not institution, give s		cci	Ab Ciby Town	or Location of De	2. Date of Dea Month April 2	27, 2	Year 2004 County of Death	3. Time of Death 4:20 A	Ą
	Examir	er	21010 Blunt Road			Germant	own		Mo	ontgomer	y	
	Funeral Director		5. Social Security Number 6. Sex 578-12-7111	M 2FTE	(In yrs. last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birth (Month, Day March 4	y, Year)	20 Lyn	place (State or Foreig intry) chburg, VA	רון
	Maryland -f show	tor	10a. State 10b. County  MD Montgome	erv	10c. City, Town or Lo						10d. Inside City Limits	
	with the a or 28s	Direc	10e. Street and Number 21010 Blunt Road			10f. Zip Code 20876			10g. Citiz	zen of What Cou	•	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "netural", or items 23e or 28e-f show empty injury or other traumatic event, it a Mydical Examir at must be notified at once.	by Funeral Director		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 [3] N If Yes, Give Year or Dates:	0		ban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		14. Race - Ameri Black, White	ican Indian,	
215-00	ithin 72 hour ie. ien "neturel	Completed t	15. Decedent's Educ (Specify only highest grade	cation	(Give	dent's Usual Occu kind of work done DO NOT use retin	ipation during most of i	working	16b. Kir	nd of Business/Ir		_
Maryland 21215-0036	should be filed wind Mental Hygien and Mental Hygien is marked other thumatic event, ILM	To Be Con	17. Father's Name (First, Middle, Last)  Harry Arthur Layne	4+ e	Admi	nistrati	18. Mother's N	stant Name (First, Middle, Mona Purc	Maiden	of Co Sumame)	mmerce	
	: 1 and 2 should be Health and Mental tem 27 is marked other traumatic ev	_	19a. Informant's Name/Relationship (Type Roberta Ricci – dau	oe, Print)		5. 11	Rd., Gei	Rural Route Numbe	-		code)	
Baltimore,	Pages 1 ament of He tant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, crea Mt. Comfo		Apr 29	il <sup>Date</sup> , 2004		cation · City or To andria,		
Bail	permit. Page Department of Important: If eny injury or		21. Signature of Fyneral Service License	Bow		2. Name and Addr		Joseph Gaw 7e. NW Was			20016	
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each lin	the death. Do not ente.	er the mode of dy	ing, such as card	diac or respiratory arr	rest,		Approximate Interval Between Onset and Death 3 years	
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):							
8760,	ate be executed hysician and the burial-transit	edical Exa	that initiated events resulting in death) Last		consequence of):							
.O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	3c. If yes, outcome of 1  Live birth 2  4  Pregnant at 1  9  Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnand Other (specify)	ey .		2	3d. Date of delive	ery Day Year	
<u> </u>	The taw requires that the to be to signed by the bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions confi	tributing to death bu	t not resulting in the u	nderlying cause g	ven in Part I.	10		_	he cause of death?	1
al Records,		Completed						24a. Was a autops perfori		24b. Were auto prior to co death? 1  Yes	opsy findings available impletion of cause of	э
Division of Vital	ng Phys Iter this ineral di	atlon; To Be	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	ospital: 1 Inpatier 28a. Date of Injun (Month, Day	ot 2 ER/Outpatier  y (28b. Time of Injury	28c. Inju	her: 4 Nursing	Death (Check only on G Home 5 X Reside 28d. Describe he	ence 6		y)	-
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc.				City or Town	n, State)		al Route Number,	
	the Hosp hin 24 ho the Fune npletely f	Medical	(Check only 2 Medical Examin	ician: To the best of er: On the basis of and manner stat	f my knowledge, death examination and/or in ed.	vestigation, in my	opinion, death oc	curred at the time, d	late and p	place, and due to	o the cause(s)	
	70	•	29b. Signature and title of certifier  Fun cercel	A Bu	v po	022	se number 775			signed (Month,		
			30. Name and address of person who cor Frederick Barr, M.	D. 5454 W	isconsin A		1345 Ch	evy Chase	, MD	20815		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 20	32. Registra	r's Signature	Ann.	W. 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** aM April Helen Mae Ridgley 23 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Under 1 Year | If Under 24 Hrs. Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 📆 F Yrs Director 83 Jan. 2, 1921 579-46-0085 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits rei', or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3000 Findley Road 20895 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White th and Mental Hygiene.

27 Is marked other than "netuintraumatic svent, in a Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed with and Mental Hygien 7 Is marked other th Deli Manager Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should bent of Health and Men ၉ Edward Brian Grimes Helen Marie Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health mportant: If item 27 3000 Findley Road Sandra L. Bennett Daughter Kensington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Parklawn Memorial Park 04/27/04 Rockville, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901
Approximate 21. Signature of Funeral Service Licens iny in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart affure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CALDED PULMENMY Physician disease or condition resulting in death) /Medical Examiner OLUNMY Scauentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page 2 No 2 No 1 Yes 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Hospital: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide thin 24 hours a 29a. Certifie 🛮 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

Registrar

SUBURBA HSPIM

BENKBON

w

32. Registrar's Signature

 $\omega$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROTERIO M)

31. Date filed (Month, Day, Year)

**APR 27** 

			1 = For State Registrar	e of Maryland / Dep	artment of Health and rtificate of Death	Mental Hygie	ne No. 2004	15315
67		Septem	Registrar  1. Decedent's Name (First, Middle, Last)	Ce	Tillicate of Death	Reg.	No.C. O U I	3. Time of Death
п	Physici			D		Month	Day Year 2004	9:39 a <sub>M</sub>
	/Medic Examir		Francis Aloysius  4a. Facility Name (If not institution, give street and	Rupp d number)	4b. City, Town, or Location of Dea		4c. County of Dea	
e .			11411 Blue Ridge Dri	ve	Beltsville		Prince G	eorge's
	Funeral		5. Social Security Number 6. Sex 1図M 2回	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth (Month, Day, Ye	ar) 9. Bir	thplace (State or Foreign ountry)
	Director		578-03-6119 Usual Residence of Decedent	82 Yrs.		June 4, 1		rginia
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Man a-1 sh	tor	Maryland Prince Georg	e's Beltsvil	1e			1 ☐ Yes 2 🔯 No
	or 28,	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	ountry?
	ath wi	ral	11411 Blue Ridge Dri	ve	20705		USA	
	ar deg	Funeral	Arme	Decedent Ever in U.S. 13. d Forces?	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	14 Va	/es 2 □ No s, Give or Dates: 1940-45	1 ☐ Yes 2 ☒ No Specify:		Specify: Whi	te
21215-0036	72 hours aftar death with the Maryland natural', or Items 23s or 28a-1 show dical Exatural must be motified at	ted	15. Decedent's Education	16a Dece	dent's Usual Occupation	16b	. Kind of Business	/Industry
215	within 7; ene. than "n	Completed	(Specify only highest grade completed in the complete state of the	ted) (Give ge (1-4or 5+)	kind of work done during most of wo DO NOT use retired)	orking		,
21	filed within Hygiene. Ither than ant, the We	Con	,		ptanalyst	Na	tional Se	curity Agenc
nd	m - 0 2	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid		
Z	2 should be and Mental ris marked o	은	William Henry Rupp			ine Gilmo		
Mai	d2st		19a. Informant's Name/Relationship (Type, Print		ng Address (Street and Number or R			
Ġ,	1 an Heal tem 2 other		Evangeline W. Rupp/ Wi 20a. Method of Disposition	20b. Place of Dispo	l Blue Ridge Driv		11e MD / Location - City or	
JOE L	ages ent of ht: If if		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Gate of	TICK VCII	11 29,		
Baltimore, Maryland	permit. Pages 1 and 2 should be Deportment of Health and Menta Important: If item 27 Is marked any njury or other traumatic es	1	21. Signature of Funeral Service Licenses	2 O			ver Spri	ng, Maryland
m	Department Department	8 17	Vallan I 13	w 50	2. Name and Address of Facility Cancis J. Collins 00 University Blv	Funeral Ho	ome Inc.	m MD 20901
	*		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	hat caused the death. Do not ent	er the mode of dying, such as cardia	c or respiratory arrest,	VCI DDIII	Approximate Interval Between
The state of	Physician		Immediate Cause (Final disease or condition	gestive Heart F	lad lums			Onset and Death 4-5 Years
	/Medical Examiner		resulting in death)	e to (or as a consequence of):	allure			4-5 leals
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	led nsit	nine	cause. Enter Underlying					
,	al-trai	Examiner	that initiated events	diac Arrhythmia e to (or as a consequence of):				4-5 Years
8760,	icate be exacuted physician and the burial-transit		L <sub>d</sub> Hyp	ertension				
9	death certificate be exacuted e attending physician and id for use as the burial-transit	Physician/Medical						
Вох	th cer tendir r use	an/h	230. Was decedent pregnant	, outcome of pregnancy ive birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deli	
о. П		slci	1 Yes 2 No	_	Other (specify)		Month	Day Year
Δ.	that the death certific ed by the attending p detached for use as		Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause away in Part I	23a Did tahaca	a usa aastributa ta	the cause of death?
ds,	es be	d by		to document to the state of the state of	nderlying cause given in a art i.		_	obably 4 Unknown
COL	w requir been si should	lete				24a. Was an		
Records,	The lavate has page 2.	Completed				autopsy performed	prior to death?	topsy findings available completion of cause of
		0	25. Was case referred to medical		26. Place of De	1 Yes 2 1 ath (Check only one)	No 1 ☐ Yes	2 No
	A S P	To B	examiner? 1 ☐ Yes 2 🖾 No Hospital:	I ☐ Inpatient 2 ☐ ER/Outpatien		lome 5∑ Residence	6 □Other (Spec	cify)
	ding Ph n. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	Pate of Injury 28b. Time of Month, Day Year)	28c. Injury at Work?	28d. Describe how in		
sio	Attending r daath. ector: After by the fune	cati	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	I or Attena after daatl Director: I in by the	ertification;	. — determined	lace of Injury - At home, farm, struilding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	Hospital 24 hours a Funeral I	0	29a, Certifier 1 X Certifying Physician: T	the best of my knowledge, death	n occurred at the time, date and place	and due to the cause	(a) and manner as	etated
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examiner: On t	ne basis of examination and/or inv manner stated.	vestigation, in my opinion, death occu	irred at the time, date a	ind place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	ha cooping	29c. License number	29d. [	Date signed (Month	n, Day, Year)
	20		I Wa Krist	na mass my	D38139	Δ	pril 28.	2004
	-		30. Name and address of person who completed	cause of death (Item 23a) (Type,	D-i*\			
			Sita Krishnamoorthy M 31. Date filed (Month, Day, Year)	D. 12201 Plum	Kaiser Per m Orchard Dr., Si	lver Sprin	g, MD 209	904
6	Sta Registr		APR 29 2004	2 Registrar's Signature	Sported			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death APRIL **Physician** 23 2004 JACQUELINE ROUDIEZ 6:00 AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner **STEVENSVILLE** QUEEN ANNE'S 301 SHIPPING CREEK DRIVE If Under 1 Year Months Days if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) AUG. 10,1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months 136-58-0551 81 Director FRANCE Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after deeth with the Marylend nent of Health end Mental Hygiene. int: If Item 27 is marked other than "natural; or Items 23a or 28a-f show 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director QUEEN ANNE'S STEVENSVILLE MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? STEVENSVILLE USA 301 SHIPPING CREEK DRIVE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) GEORGE STRICH CECILE BERTHE FELICIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health er important: if item 27 is any injury or other trau 104 JEAN ROAD, STEVENSVILLE, MD FRANCIS ROUDIEZ/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 04/24/2004 STEVENSVILLE, MD 21. Signature of Funeral Service License 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one pause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner インナセ attending physician and for usa as the burial-transit Hospital or Attending Physician: The law requiras that tha death certificeta ba executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 Probably 4 → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 □ Yes 2 □ 1No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 Yes 2 No After this funeral di 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

within 24 hours eff

To the Funeral Di

completaly filled in

State Registrar

edicai

29a. Certifier

(Check only

29b. Signature end title of certifier

JAMIE HARMS, MD

31. Date filed (Month, Day, Year)

in m

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)



130 LOVE POINT ROAD,

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es steted

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number

041339

STEVENSVILLE, MD

29d. Date signed (Month, Day, Year)

		State Registrar  1. Decedent's Name (First, Middle, Last)		ertificate of Death	Reg.	3. Time of Death					
Physici /Medic Examir	al	4a. Fecility Name (If not institution, give street and		4b. City, Town, or Location of Death BALTIMORE	1 11 1	25 2004 16:19 PM 4c. County of Deeth					
Funeral Director		UNIVERSITY OF MACYLAND  5. Social Security Number  147–18–5507  6. Sex  1 M 2 X	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye May 12,						
a-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         Talbot	10c. City, Town or	Location Trappe		10d. Inside City Limit 1 ☐ Yes 2 💆 N					
3a or 28	Funeral Director	10e. Street and Number 29811 Bolingbroke Pt	. Dr.	10f. Zip Code 21673	10g.	Citizen of What Country? U.S.A.					
natural, or flems 23a or 28a-f show dical Examiner must be notified at	by	1 Never Married 2 Married 1 1 Ye	Decedent Ever in U.S. d Forces? /es 2 15 No s, Give or Dates:	3. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 Tyes 2 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
then.	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12)  11  Colle	ge (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of won b. DO NOT use retired) homemaker	king 16b	own home					
Mental Hygid Mental Hygid Marked other Maric event, II	To Be Co	17. Father's Name (First, Middle, Last) unknown			ne (First, Middle, Maio Berniere	<sub>den Sumame)</sub> Parisiene					
and farm	-	19a. Informant's Name/Relationship (Type, Print		ailing Address (Street and Number or Ru							
nt: K ryor											
permit. rage Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Th 700 Locust St., Ca							
Thicate be executed by Science of Street Property of physician and as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	MULT IS YST e to (or as e consequence of): SEPTIC SHO e to (or as a consequence of):	EM ORGAN TAILURE  XXX  MMUNDSUPPRESSION		Interval Between Onset and Death					
attendir for use	Physician/Medic	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year					
been signed by the should be detached	Ď	Part II. Other significant conditions contributing DERMADMYC	•	e underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Unknov					
ate has bee	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 ☒	24b. Were autopsy findings availated prior to completion of cause of death?  No 1 Yes 2 No					
is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital:	1 ☑ Inpatient 2 ☐ ER/Outpa	Othor	ith (Check only one)	e 6 ☐Other (Specify)					
ding Pring h. After thi funeral c	Certification; T	27. Menner of Death 1. Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year) 28b. Time Injur	e of 28c. Injury at	28d. Describe how i	njury occurred					
ath or:	ertific		Place of Injury - At home, tarm, building, etc. (Specify)	street, factory, office	28t. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)					
ital or Alterior its after death. ral Director: A led in by the fu	O	29a. Certifier 12 Certifying Physician: 1	the best of my knowledge, de	eath occurred at the time, date and place	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
• Hospital of Attend 124 hours after death • Funeral Director: letely filled in by the i		(Check only 2 Madicel Examinar: On	the basis of examination and/or manner stated.	rinvestigation, in my opinion, death occu		in the second se					
To the Hospital or Attending within 24 hours after death To the Funeral Director: completely filled in by the life of the property of the prop	Medical C	(Check only 2 Madicel Examinar: On	manner stated.	29c. License number  AU 4176435 7	29d.	Date signed (Month, Dey, Year)  April 25, 2004					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 15318 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year May 5, 2004 Ada Stumpf 6:00 am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Nursing Center Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, NOV 7, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ VF 216-66-0584 Director 90 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28e-f shormust be notified at PA Bedford Bedford Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 365 Evitts Creek Road 15522 USA Funeral death r then "netural", or items 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No io. 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: ρ Specify: 3 XWidowed 4 □ Divorced white Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Charles Lesh Elizabeth Lesh ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma Ware daughter 365 Evitts Creek Road **Bedford** PA 15522 Department of Health a Important: If item 27 is any injury or other tra 20b, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Sunset Memorial Park 5/8/2004 MD 4 ☐ Donation 5 ☐ Other (Specify) Cumberland 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> and Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. anns Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myrzadich infactor minutes Examiner Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Division of Vital Records, P.O. Box Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 3 Probably 4 ☐ Unknown cate has been signed by page 2 should be detact 1 ☐ Yes 2 ☐ No COPD Ş Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 X No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 Tes after death. 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred or Attending **1**∕2 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital or within 24 hours at To the Funerel D Medical 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified

Cumberland Ild 215

Registrar **DHMH 16 Rev 6/95** 

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALMIS

31. Date filed (Month, Day, Year)

32. I

302

MIJARGY SCHAFFER

			. For	State of N	Maryland		artment of H		Mental Hy	giene		
			State Registrar			Cer	tificate of	Death		Reg. No.2	004	15320
	Physicia	20	1. Decedent's Name (First, Middle, I	.ast)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Anna Katherine						April		004	8:00 PM M
	Examin	er	4a. Facility Name (If not institution, g					Location of Death		4c. Cou	unty of Death	1
_			Shady Grove Adver		ing Ce Age (In yrs. la		If Under 1 Year	ockville If Under 24 Hrs.	8. Date of Bir	th		omery place (State or Foreign
	Funeral Director		202-01-7504	1 □ M 2 🕅 F	83	Yrs.	Months Days	Hours Min.	(Month, Da	ly, Year)	l Coi	nsylvania
	ъ		Usual Residence of Decedent						1			
	arylar show	١	10a. State 10b. County			, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No
	he M	Director	Maryland Montgo	mery	Gai	thersb				10- Citi		
	a or		17.000 IZ	77 // 1/ 1			10f. Zip Code			10g. Citizen		
	death with the Maryland ms 23a or 28a-f show	Funeral	17009 King Jame	12. Was Deceder	nt Ever in U.S	S. 13. V	20877 Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No		d Sta	ican Indian,
0	or Itar		1 Never Married 2 Married	Armed Force			fYes, specify Cuba 1 □ Yes 2X No		o Rican, etc.)		Black, White	
212-003a	ours a	1 by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates	s:		ILITES ZALINO	Specify:		Spe	<sup>ecify:</sup> Whi	te
2	72 h natu	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of wor	rking	16b. Kind o	of Business/I	ndustry
٧	withir ane. than	mp	Elementary/Secondary (0-12)	College (1-4c	or 5+)		maker	"		0	II om o	
7	filed Hygie other ant, I	e Co	17. Father's Name (First, Middle, La	st)		поше	maker	18. Mother's Nan	ne (First, Middle	Own , Maiden Sun		
/land	ld be ental ked c	To B	Mark Daniel Wil	lenbecher				Mary Se	nia Rep	pert		
ar >	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-1 show aumatic evant, it a Marical Examiner man be notified at	_	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street			•	wn, State, Z	ip Code)
, Mar	and 2		Darlene Mary Br	own/Daught				mes Way,	#101,	Gaithe	rsbur	MD 20877
ore Ore	of He		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3	□ Removal from Sta	20b. Pl	ace of Dispo	sition (Name of natory or other place Y	May	Date 1,	20c. Location	on - City or 1	own, State
Ě	ment ment:		* 4 □ Donation 5 □ Other (Spe	city)	Cre	mātori	um Inc.	2004	+	Bet	hesda	, Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic ev once.		21. Signature of the Service Lice	ensee De Lu	.M0080	)3   <sup>22</sup> F	Name and Addre Rockville Rockville	ss of Facility Rol , Inc. 30 , Marylai	bert A. 00 West nd 20850	Pumphr Montgo 2805-	rey Fu omery	neral Home/ Avenue
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that causely one cause on each	ed the death	. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Demen								Onset and Death  1 Year
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):						
	Lammer	er	Sequentially list conditions, if any, leading to immediate	b	as a consequ	ence of):						
	ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0)	as a consequ	once or).						
	execunand nand ial-tra	Examin	that initiated events resulting in death) Last	c. Due to (or	as a consequ	rence of):						
2/60	ficate be executed physician and is the burial-transit	cal		d								
٥	tificat ng ph) as th	b	15.55.44.5									
X Q Q	the death certific y the attending p iched for use as	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon 1 ☐ Live birth	ne of pregnar 2  Fetal		Ectopic pregnancy				Date of deli-	very Day Year
	e dea the at	Physici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant 9□ Unknown		eath 5	Other (specify)				WIGHT	Day real
7		Phy	Part II. Other significant conditions	s contributing to death	but not resu	ilting in the w	ndertving cause giv	en in Part I.	23e, Did t	obacco use c	contribute to	the cause of death?
Kecords,	w requires that been signed b should be deta	d by	Atrial Fibrilla	9			,,		10	Yes 2□No	o 3 🗆 Pro	bably 4 XUnknown
S	> 9 70	Completed	Thrombocytopeni	a					24a. Was	an 24	b. Were aut	opsy findings available
T E	e la has	duo								rmed?	death?	ompletion of cause of
VII		O	Gastrointestina. 25. Was case referred to medical					26. Place of Dea	1 ☐ Yes ath (Check only o	2 <b>X</b> No	1 🗆 1 03	213140
> 10		To B	examiner? 1 □ Yes _2 XNo	Hospital: 1 🗌 Inpa	atient 2 🗆 E	ER/Outpatien	t 3 DOA Oth	er: 4 📉 Nursing H	lome 5 🗆 Resi	dence 6 🗆	Other (Spec	ify)
0 00	ding Phys h. After this funeral di	Certification:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date of II (Month, I	njury Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury oc	curred	
UNISION	Attano or death actor: by the	ifica	3 Suicide 6 Could not determine	t be 28e. Place of	Injury - At horests. (Specify	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and Nu	umber or Ru	ral Route Number,
5	tal or	Cert	- I nominae	Danianty,	0.0. (0,000)				J., J.			
	To tha Hospital or Attanding within 24 hours after death.  To tha Funaral Diractor: After Completely filled in by the funer	Medical		Physician: To the be caminar: On the basis and manner	of examinat							
	To th withir To th Comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date sig	gned (Month	Day, Year)
	(		Dass.				D286	56		Арі	ril 29	, 2004
			30. Name and address of person wh				Print)					
			Ravi Passi, M.I		Shady strar's Signat		Road, #2	08, Rock	ville, N	<u>larylar</u>	nd 20	850-3258
*	Sta Registr		APR 3 0 2		strar's Signat	4	Sparks	/				

			1 - For State Registrar	State of Ma	ryland	-	artment <i>tificate</i>			ınd Me		giene,	2001	15321
Ä	च क्रिक्ट		Decedent's Name (First, Middle, Last)							2	. Date of Dea	ıth		3. Time of Death
	Physicia		PAUL	KEVIN	SCHE	REIBER					Month APR	Day 26	2004	7:35 <sup>AM</sup>
7	/Medic Examin		4a. Fecility Name (If not institution, give s		Dom	CELEBER	4b. City, T	Town, or	Location of	f Death		7	County of Dec	
	LAGIIIII	e i	NATIONAL NAVA	L MEDICAL	CENT	rer		BE	THESD	ρA		M	ONTGON	MERY
П	Funeral		Social Security Number 6. Sex		(In yrs. la	ast birthday)	If Under	1 Year Days	If Under 2 Hours	24 Hrs. 8	. Date of Birth (Month, Day			rthplece (State or Foreign country)
	Director		172-48-2388	M 2□ F	47	Yrs.	Mortus	Days	Hours		UG. 15		56	PA.
	D		Usual Residence of Decedent		10a City	, Town or Lo	antion							10d. Inside City Limits
	aryla	_	10a. State 10b. County		TOC. City	, TOWN OF LO								1 X Yes 2 □ No
	8a-1	Directo	VA. NONE				ALEXA		LA			40- 025-		
	vith ti	5	10e. Street and Number				10f. Zip					iog. Citiz	en of What C	
	s 23s	ra	1213 W. BRADD		une in 11 C	121	Man Deced	223		ring (Chaoi	fu Vac as Na	1	U.S	• A •
	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show Jisal Examinat must be notified at	Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married	2. Was Decedent E Armed Forces?		5. 13. 1	f Yes, speci	rfy Cubar	n, Mexican	, Puerto Ri	fy Yes or No- can, etc.)	'	Black, Wh	
5	rs aft	by F	3 Widowed 4 Divorced	1 X Yes 2 Ne If Yes, Give Year or Dates:	1982 200	7	1 ☐ Yes 2	2⊠ No	Specify:				Specify:	WHITE
215-0036	72 hours natural',	ed	15. Decedent's Educ		200	16a. Deced	ient's Usual	l Occupa	ition			16b. Kin	d of Busines	
<u>د ا</u>	n n n	Completed	(Specify only highest grade	College (1-4or 54	4.)	(Give life. l	kind of worl DO NOT use	k doné d e retired)	uring most	of working	'			
717	d within piene. r than	E	Elementary/Secondary (0-12)	5+	+)	τ	J.S. M	IARIN	ΙE			]	DEFENS	Е
0	il Hygi other	BeC	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (	First, Middle,	Maiden S	Sumame)	
<u>a</u>	A P D S	To B	PAUL C.	SCHREIBE	R						ELLEN	M	URPHY	
Maryland	s 1 and 2 should if Health and Men item 27 is marke other traumatic	_	19a. Informant's Name/Relationship (Ty)	oe, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rural I	Route Numbe	r, City or	Town, State,	Zip Code)
	and 2 Balth a n 27 is		GRETCHEN SCHREI	BER/WIFE		1213	W.	BRAD	DOCK	RD.,	ALEXA	NDRI	A, VA.	22302
อ์	es 1 a of Hea f Itam r othe		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Nam	ne of ther place	•)	Dat	9	20c. Loc	ation - City o	r Town, State
Ē	Pages nent of nnt: If it		1 Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from State		LINGTO	•		. 1	6-9-2	004	AR	LINGTO	N, VA.
altimore,	permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service License	197 53	•						E & CR			
ñ	Ped E a		W.M. Chame	rua	M00	091 58	IAMBER 301 CL	EVEI	LAND A	AVE.	RIVER	EMATO DALE	MD.	20737
2			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused e cause on each line	the death									Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	. ACUTE  Due to (or as a			C ISCH	HEMI	A					
	Examiner			Due to tot as a	consequ	ierice oi).								
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequ	ience of):								1
	per l	듣	cause. Enter Underlying Cause (Disease or injury											
,	be execuled ician and burial-trarisit	Exan in	that initiated events resulting in death) Last	Due to (or as a	consequ	ience of):								
8760	cate be executed by sician and the burial-tran	dical												
8	ificati g phy as the	edic											`	
ŏ	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	an/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of			70-40-10-10					2:	3d. Date of de	elivery
n	death e atte	icla	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 Live birth 4 Pregnant at t			Ectopic pre Other (spe						Month	Day Year
Ö	at the de by the a tached	Physica	9 Unknown	9 Unknown										
יה מי	igned be deta	by P	Part II. Other significant conditions con	tributing to death bu	t not resu	ilting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute	to the cause of death?
ĕ	w require been sig should b										1 □ Y	es 2X	]No 3 ☐ F	robably 4 Unknown
ecords,	law requas been 2 should	olet									24a. Was a		24b. Were a	utopsy findings available
ř	e – e	Completed									autop perfor 1 Yes		death?	completion of cause of s 2 No
Vital R	ilcian: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death (	Check only o		10310	3 20,110
	A 0 D	0 8	examiner? 1 ☐ Yes 2 💢 No	ospital: 1 📉 Inpatier	nt 2 🗆 E	ER/Outpatien	t 3 DO	A Othe	ır: 4 □ Nuı	rsing Home	5 ☐ Resid	lence 6	Other (Spi	ecify)
0	g Ph er thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time of	28	8c. Injury Work	at		d. Describe h			
Ö	Attending in death.	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(1110111111, 22)	, 64,	111,017	М		/es 2□N	No				
DIVISION	after deatl Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At ho	me, farm, str	eet, factory,	, office		28	f. Location (S City or Tow	treet and	Number or F	Rural Route Number,
ā	s afte	Cer		,	. ()	,								
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of and manner stat	examinat	wiedge, death ion and/or in	n occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, an th occurred	d due to the o at the time, o	ause(s) a date and p	and manner a place, and du	is stated. le to the cause(s)
	Fo th Mithin Fo th Compl	Me	29b. Signature and title of certifier	`			29c.	. License	number		- 4	29d. Date	٠,	oth, Day, Year)
,	0		Vann Alla	min_ K	NA	-	GI	FE588	817 (	CA)			4/2	7/04
1	1+1		30. Name and address of person who co	mpleted cause of de	eath (Item	23а) (Туре.				- the street was	AL MED	TCAT.		
			HANS A. BRINGS	CAPT MC		_					20889~		CHATE	IX.
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signat		1		4		-555			
	Registr		APR 3 0 20	14 Mayor	care	B	papa	acks						

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar	State	of Marylan				lealth a Death			giene Reg. No.	71111	15322		
CONT.	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	70	1. Decedent's Name (First, Middle	2. Date of Death Month					ath Day	Day Year						
	Physici /Medic		Isaak Slezinger					4-27-0								
	Examin	4 100	4a. Facility Name (If not institution	n, give street and	number)		4b. City,	Town, or	Location of	of Death		4c.	th			
			4521 East-West		T 2			hesd	a If Under	24 Hrs. 1	0 D-1(Dia		ntgome			
Ε.	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Day	y, Year)	C	thplace (State or Foreign ountry)		
· .	Director		218-27-0868 Usual Residence of Decedent		81		l	L	]		3-22-	23	UKT	aine		
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation		-					10d. Inside City Limits		
	Many itsh	to	MD Mont	gomery	Ret	thesda								1 ☑ Yes 2 ☐ No		
	r 288	Director	10e. Street and Number	Somery		<u> </u>	10f. Zij	Code				10g. Citi	zen of What C	ountry?		
	filed within 72 hours after death with the Maryland Hygione. ther then "natural", or Itema 23a or 28a-f show ont, the Macical Examinar must be notified at		4521 East-West Hgwy.					20814					S.A.			
	deat	Funerai	11. Marital Status		ecedent Ever in U Forces?	J.S. 13.	Was Dece	dent of H	ispanic Ori	gin? (Spec	cify Yes or No-		14. Race - Am- Black, Whi			
9	after or Ite	F.	1 ☐ Never Married 2 ☑ Mar	ried 1 ☐ Ye	s 2 No		1 ☐ Yøs		Specify:		,		Specify:	White		
	ural',	d by	3 Widowed 4 Divorced	Year o	or Dates:	1										
<u>7</u>	nati	Completed	15. Deceder (Specify only highe	it's Education st grade complete	npleted) (Give			dent's Usual Occupation kind of work done during most of working DO NOT use retired)			g	16b. Kı	/Industry			
2	withir ane. then	d L	Elementary/Secondary (0-12)	Colleg 5+	e (1-4or 5+)				″ Mathe			Ed	lucation	n		
0 0	Hyginther ther	ပို	17. Father's Name (First, Middle,	Last)							(First, Middle,	Maiden	Sumame)			
_	_ 0 9	To Be	Nison Slezinge	r					Pa	ulina	Kanev	esky	7			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other then "natural", or Itemas 23a or 28a-1 show important: If item 27 is marked other then "natural", or Itemas 23a or 28a-1 show enty into your part of the Maryland Experiment mast be notified at once.	ĭ	19a. Informant's Name/Relations Eleonora Slezi		aughter								r Town, State,	Zip Code) MD 20886		
altimore, I	is 1 and of Health item 27		20a. Method of Disposition		20b. F	Place of Dispo	osition (Na	me of			ite		cation - City or			
Ë	Page int: If		1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other (5		UIII SIAIB	. Linco				4-29-	-04	Bren	twood,	MD		
alti	mit. partn porta y inju		21. Signature of Funeral Service	Licensee	0 1	22	2. Nam <i>e</i> a	nd Addres	ss of Facilit	ty Hir	es-Rin	aldi	F. H.			
m	\$2 E 2 8		Duane	les l	spill	11	1800	New 1	Hamps	hire	Ave. S	ilve		ng, MD 20904		
C			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications th	at caused)the dear	th. Do not ent	ter the mo	de of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between		
	Physician		fmmediate Cause (Final disease or condition Cholangiocarcino										Onset and Death $1\frac{1}{2}$ yrs.			
	/Medical Examiner		resulting in death)	quence of):												
#i		2	Sequentially list conditions,	b	Due to (or as a consecusing of):											
4	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	puanda of):												
	and I-tran	хап	that initiated events resulting in death) Last Oue to (or as a consequence of):													
8760,	death certificate be executed e attending physician and id for use as the burial-transit	calE														
687	phys s the	edic		0												
Вох	leath certifical attending plates as t	N/M	IF FEMALE: 23b. Was decedent pregnant	23b. Was decadest program 23c. If yes, outcome of pregnancy								23d. Date of delivery Month Day Year				
ă	death a atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pr	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)											
O.		hys	9 🗆 Unknown	91.10	nknown											
ds, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant containons continuously to death out for lossiting in the discerning seaso given								23e. Did to		o use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
of Vital Records,	w requires t been signe should be	Completed									24a. Was	an	24b. Were a	utopsy findings available		
Re	o - 6	m									autop perfo	rm <i>e</i> d?	prior to death?	completion of cause of		
a	ician: Th certificate rector, pag	e Co	25. Was case referred to medical	1	CO Plant of Park (					1 Yes		1 L Ye:	s 2 No			
5	Physician: rthis certifica ral director, i	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	☐Inpatient 2☐	ER/Outpatier	26. Place of Death (Check only one)  26. Place of Death (Check only one)  Jent 3 □ DOA Other: 4 □ Nursing Home 5 ☒ Residence 6 □ Other (Specify)						acify)			
	ding Phy n. After this funeral c		27. Manner of Death  1 Natural 2   Accident investigation   2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   4   Accident   Accid					of 28c. Injury at Work? 28d. Describe					how injury occurred			
Sic	Attending r death. ector: After by the fune	icat						M 1 Yes 2 No			8f Location /5	(Street and Number or Rural Route Number,				
Division	tal or Attenders after deatles al Director:	Certification:						citreet, factory, office 251. Location (street and Number or Hural Houte Number City or Town, State)					arai ridata riambar,			
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		Examiner: On th	the best of my known the basis of examination that the basis of examination that the basis of th											
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Da								th, Day, Year)					
	/	l la	121	6 2	12	1201		Ι	22775	5		4-	28-2004			
	>		30. Name and address of person	who completed												
			Frederick G. Ba				Park	Dr.	Suit	e 200	), Silv	er S	pring,	<sup>MD</sup> 20902		
	Sta Regist		31. Date filed (Month, Day, Year APR 29		2. Registrar's Sign	ature	do	arka	1							

			1 - For State Registrar	State o	f Maryla		artment of H				giene, Reg. No.	200	Ļ	153	323
	Physicia	an	1. Decedent's Name (First, Middle, Last)							Month Day Year			3. Time of 3:00	Death A M	
	/Medic		Louise 0.	Stewart	- 6 - 1		4b. City, Town, or	. Longtion	of Death	April 2		County of De			
	Examin	er	4a. Facility Name (If not institution,	give street and nu	m <i>ber)</i>		Bethesda	Location	of Death		46. (	Montgo			
H	Euporol		Andrus House  5. Social Security Number 6. Sex 7. Age (In yrs. last t			. last birthday)	If Under 1 Year		24 Hrs.	8. Date of Birt	te of Birth 9. Birthplace (State or Foreig				r Foreign
	Funeral Director		496-32-5983	1 ☐ M 2 🔀 F	103	l Yrs.	Months Days	Hours	Min.	January	25, 19	903 K	Country	5	
	D .		Usual Residence of Decedent  10a. State 10b. County		10c C	ity, Town or Lo	ecation						10d	Inside Cit	ty Limits
	sho	5				Lean								1 🗀 Yes	
	ith the Marylan or 28a-f show	Directo	Virginia Fairfa:  10e. Street and Number	ζ	PRO	Lean	10f. Zip Code				10g. Citiz	en of What	Country	?	
	3e or	0	1633 Evers Drive				22101				τ	JSA			
	72 hours after death with the Maryland Insturat; or Itams 23e or 28e-f show Jeal Expriment of the conflict	Funeral	11. Marital Status	12. Was Dec	edent Ever in I	J.S. 13.	Was Decedent of H	ispanic Ori	igin? (Spe	cify Yes or No-	1	4. Race · A			
Ď	or Its		1 Never Married 2 Marri	ed 1 □Yes If Yes, Gi	2⊠No ve		1 ☐ Yes 21 No	Specify:				Specify:			
2-003d	hours tural;	ed by	3 Widowed 4 Divorced	ates:	16a Dece	dent's Usual Occup		- M	of Business/Industry						
6	in 72 "nal	Completed	(Specify only highest grade completed) (Give kind of work done during tife. DO NOT use retired)						st of workir	TOD. IVIII	Killd of Business/illdustry				
7	d with giene. ir than	E O	Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker							Own	Own Home				
aud	al Hyg	Bec	17. Father's Name (First, Middle, I	Last)				18. Mothe	er's Name	(First, Middle,	Maiden S	Sumame)			
ıaryıar	Menta Menta arked	2	Fred Caster							miklaus					
	2 short and rism		19a. Informant's Name/Relationsh				ng Address (Street : Evers Drive				r, City or 22 <b>1</b> 0		e, <i>Zip</i> Co	ode)	
e)	1 and Health BIT 27 thar t		Fred W. Pickett (S	On)	20b.	Place of Dispo	osition (Name of	-		ate		ation - City	or Town	, State	
و	ages int of it. If it.		1 Burial 2 Cremation		State	cemetery, cre Crematio	matory`or other place n. Center	(e)	4/27/	<b>′</b> 04		tilly,			
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours attar death with the Marylai Department of Health and Mental Hygiens. Important; it flam 23 to a raked other than "hatural; or Itams 23e or 28a-f show any injury are other traumatic event, it a Medical Examination and be natified at once.		' 4 □ Donation 5 □ Other (Sp 21. Signature   Funeral Service	77			2. Name and Addres	ss of Facili				/,	0	_	22046
n	Dep Imp any		Konneds	MM	ARN/	M	iurohy Funer	al Hom	ne, 110	02 W. Bro	ad St	., Fal	ls Ch		
			Murphy Funeral Home, 1102 W. Broad St., Falls Church, Va.  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Control and Death Control an										e ween		
	Physician	-	Immediate Cause (Final disease or condition									Death			
	/Medical		resulting in death)  Due to (or as a consequence of):												
	Examiner	ا _ ا	Sequentially list conditions,												
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
_	and and al-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):										1		
8/PU	death certificate be executed eathoring physician and attending physician and for use as the burial-transit	cal													
Õ	fificate ng phys as the	73	IE EENALE.	11)											
X R R	th certendir	an/h	IF FEMALE: 23b. Was decedent pregnant	as decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy							2	23d. Date of delivery  Month Day Year			
5	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown								ŀ				
ì	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						I.	23e. Did tobacco use contribute to the cause of				cause of d	eath?
ďS,	signe d be	d by	,							1 Yes 2 No 3 Probably 4				y 4 □U	Inknown
Ö	been been shoul	Completed		24a. Was										available	
Ä	The law ite has b page 2 si	dwc	autopsy performe  1 □ Yes							rmed2					
Vital Record		O O	25. Was case referred to medical					26. Place	e of Death	(Check only o					
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1	Inpatient 2[	☐ ER/Outpatie	nt 3 DOA Oth	er: Ni	ursing Hon	lome 5 ☐ Residence 6 ☐ Other (Specify)					
n of	g = 2		27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work?							28d. Describe how injury occurred					
<u> </u>	tandi leath. tor: A the fu	catl	2 Accident investig	2 Accident investigation M 1 Yes 2 No						28f. Location (Street and Number or Rural Route Number,					har
Division	iel or Attanding PI s after death. al Director: After the ed in by the funeral	Certification;	4 Homicide  4 Homicide  4 Homicide  4 See. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)						ľ	City or Town, State)					D61,
_	To the Hospitel or Attanding within 24 hours after death.  To tha Funaral Director: After completely filled in by the fune	a C		g Physician: To th											
	To the Hospitel within 24 hours a To tha Funaral C completely filled	ledical	(Check only   Medical	Examiner: On the I and mar	pasis of examination of stated.	nation and/or in	ivestigation, in my o	pinion, dea	ath occurre	ed at the time,	date and	place, and o	due to th	e cause(s	)
	To the To the comp	M	29b. Signature and title of fertifie	1-5			29c. Licens	e number	Un	0, -	29d. Date	signed (Mo	onth, Da	y, Year)	
F.	3		proly	1 XM	~ im		01	010	777	717	4-	26-	04		
				who con lated cau	_	em 23a) (Type	Print)	A 2 1	2	DA	mo	10.11.	12	w	
		ate	31. Date filed (MonthsDay, Year)	32.	Registrar's Sign	nature	212 CN	41~	10/0	2 29	17.0	٠٠٠٠٠	1		
	Sta Regist	ate rar	31. Date filed (Monthsday, Year)	2004	Seneral	19	29c. Licens O 1 Print) 515 Ch.	21							

			1 - For State of Ma	aryland / Depa	artment of H rtificate of L		F	Reg. No. 2	004	153	24		
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Kathleen A.	Touch	nette		2. Date of Dea Month April	Day 29,	2004	3. Time of D	Death <b>a</b> M		
Ş.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	1040.	4b. City, Town, or	Location of Death			unty of Death	0.00			
			32 Club Lane  5. Social Security Number 6. Sex 7. Agr	e (In yrs. last birthday)	Earlev If Under 1 Year	ville If Under 24 Hrs.	8. Date of Birtl	Cecil					
ľ	Funeral Director		5. Social Security Number 221-28-3613  Usual Residence of Decedent  6. Sex 1 □ M 2 ★ F 7. Age	61 Yrs.	Months Days	42 Dela	lace (State or litry)	roreign					
36	yland how		10a. State 10b. County	10c. City, Town or Lo					1	Od. Inside City			
	he Ma	ector	Maryland Cecil	Earle	ville			10a Citizon	of What Cour	1 <b>X</b> Yes 2	2   No		
	3a or 2	i Dir	10e. Street and Number 32 Club Lane		2191	.9			ed Stat				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Department is time 27 is marked other then "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Madical Examinal must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married  2 Married  1 Yes 2 N If Yes, Give  Year or Dates:	lo l	Was Decedent of Hi. If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		Race - Americ Black, White, ecify: Whi	etc.			
21215-0036	72 hou natura iical E	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	luring most of work	sing	16b. Kind	of Business/Inc	dustry			
121	within ane. then "	Completed	Elementary/Secondary (0·12)  College (1-4or 5	+) life.	DO NOT use retired, pervisor	)		Tnem	cance				
д 2	illed Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)	Du	ZEL VISOL	18. Mother's Nam	e (First, Middle,						
Maryland	ould be Menta Merked Arked	ToB	Charles Eben Alfree, Sr.	Mary Smith									
Mar	d2 sh th and th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  Gerald J. Touchette/Husbar		ng Address (Street a Club Lane,					,			
Je,	of Heal of Heal item ?		20a. Method of Disposition		osition (Name of matory or other place		Date		ion - City or To				
iii Ei	Page Iment tant: If jury or		1  Burial 2  □ Cremation 3  □ Removal from State '4 □ Donation 5 □ Other (Specify)	Glebe Ce	metery	May 3	3, 2004	New C	astle,	Delawa	re		
20a. Method of Disposition  1 September 2 Date 2 Da													
Box 68760,	ate be executed  Thysician and the burial-transit	Ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in July that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
	death certific e attending p od tor use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of deli			ear					
rds, P.O.	se Ped	by	Part II. Other significent conditions contributing to death b		s. Did tobacco use contribute to the cause of de 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Un								
of Vital Records,	The law requir cate has been si page 2 should I	Completed			_ =		24a. Was a autop perfor 1 🗆 Yes	sy med2/	prior to cor death?	psy findings av npletion of cau	railable use of		
Vita	Physicien: this certition ral director, I	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3 DOA Othe	26. Place of Deat	th (Check only of		Other (Specif	4)	-		
on of	I or Attending Physiclen: The I after death. Director: After this certificate ha I in by the funeral director, page	tlon: To	27. Manner of Death 1 Natural 5 Pending (Month, Da		f 28c. Injury Work		28d. Describe h			//			
Division	al or Attending s after death. st Director: After sd in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office City or Town, State)								er,		
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best 2 Medical Exeminer: On the basis of and manner sta	examination and/or in			red at the time, o	date and pla	ce, and due to	the cause(s)			
	To the To the comp	Z	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day)  40035860  4/29/04  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  IVING M. Derkowitz 100  29c. License number  40035860  4/29/04										
	12		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print)  Conlato	10 St 18	La Pa	4/0	2410	T 1)=10,	712		
	Sta Registr		31. Date filed (Month, Defr. Year) 82. Registr  APR 3 0 2004	ar's Signature	de la	1 16-10	UNACY	TVEL	Mes !!	5001	110		

			1 - For State Registrar	State of Maryland / Depa	artment of Health and I ctificate of Death	Mental Hyglen Reg. N			
	Physici		1. Decedent's Name (First, Middle, Last) Charles Stephen 1	rigonoplos		2. Date of Death Month Di	ay Year 3. Time of Death 10:30 P M		
<b>\</b>	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s 8758 King George 5. Social Security Number 214-32-3223	ctreet and number)	4b. City, Town, or Location of Death Pomfret If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	c. County of Death Charles		
	e Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Charles	10c. City, Town or La			10d. Inside City Limits 1 ☐ Yes 🔏 No		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Exertimes the modified at once.	Funeral Director	10e. Street and Number  8758 King George C  11. Marital Status		10f. Zip Code  20675  Was Decedent of Hispanic Origin? (Styles, specify Cuban, Mexican, Puerly Cuban, Puerly Cuban, P		itizen of Whal Country?  USA  14. Race - American Indian, Black, White, etc.		
-0036	hours after stural, or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1954-62	1 ☐ Yes 2 ☒ No Specity:	16h	Specify: White		
C	filed within 72 Hygiene. other than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	kind of work done during most of work done during most of work DO NOT use retired)  Director	, .	ederal Railway Mministration		
arylan	should be find Mental Hamked of	To Be	Constantine Augustu  19a. Informant's Name/Relationship (Ty,			lorence Kel	ler		
	Pages 1 and 2 nent of Health a int: If Itam 27 Is iry or other trad		Patrick S. Trigono  20a. Method of Disposition  1 Disposition 3 DR	emoval from State 20b. Place of Dispo cemetery, crer	natory or other place)	Date 20c. I	Location - City or Town, State		
	permit. Pa Departmer Important any injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	99 A MOOO53 22	Veterans' Cem. 5 Name and Address of Facility Intt Funeral Home O. Box 156, Wal		eltenham, MD 1604		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not ent le cause on each line.  Due to (or as a consequence of):	er the mode of dying, such as cardial	the tree	Approximate Interval Between Onset and Death		
68760,	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):					
. Box (	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death? 2⊠No 3 Probably 4 Unknown		
Ě	The zate his page	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ N			
of Vit	ding Physician: h. After this certific funeral director,	To Be	25. Was case referred to medical examiner?  1   Yes 2   No	lospital: 1  fnpatient 2 ER/Outpatien	0.4	ath (Check only one)	6 Other (Specify)		
Division o	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred  3 Suicide 4 Homicide  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  28d. Describe how injury occurred  3 Could not be determined  4 Describe how injury occurred  5 Could not be determined						
	he Hospit in 24 hour he Funera pletely fille	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	sician: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause(	s) and manner as stated.		
)	To ti withi To ti com	Σ		. Tagour: MI	0 000		ate signed (Month, Day, Year)		
B	31281	Vf	11	mpleted cause of death (Item 23a) (Type, MD, 25500 Point Lo 32. Registrar's Signature		ardtown, MD	20650		

			1 - For State Registrar	State of Maryland / Dep Ce	ertificate of Death		ene g. No. 2001	15326
			1. Decedent's Name (First, Middle, Last	)		2. Date of Death Month		3. Time of Death
	Physici /Medio		EDWIN ROCKFORD THO	MPSON, JR.			4. 2004	4:10P_ M
	Examin		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Dea	ith	4c. County of Dea	
			Laurel Regional H	ospital	Laurel		Prince G	eorge's
	Funeral Director		5. Social Security Number 6. Se 579–24–8676	X 7. Age (In yrs. last birthday, 76 Yrs.	/ If Under 1 Year If Under 24 Hr Months Days Hours Mir		Year) Co	hplace (State or Foreign buntry) hington, D.C.
	Mc II		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Mary	ŏ	Maryland Prince (	George's Beltsvil	lle			1 ☐ Yes 2 ☑ No
;	288	rec	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	ountry?
3	38 0		4508 Tonquil Place	5	20705	Ţ	Jnited Sta	tes
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ame	
۰	or Its	교	1 Never Married 2 Married	Armed Forces? 1XYes 2 □ No If Yes, Give	If Yes, specify Cuban, Mexican, Pue	no Hican, etc.)	Black, Whit	e, etc.
3	rai.	l by	3X Widowed 4 □ Divorced	Year or Dates: WWII	1 ☐ Yes 2√2 No Specify:		Specify:	White
21215-0036	should be lied within 72 hours after death with the maryland and Mental Hygiene. The marked other than "natural" or Items 23a or 28a-f show marked other than "natural" or Items 12a or 28a-f show imatic event, Ite Medical Examinar must be incitified at	Completed	15. Decedent's Edu (Specify only highest grad	le completed)   (Give	edent's Usual Occupation  e kind of work done during most of we	adian	6b. Kind of Business	,
5	10 10 10 10 10 10 10 10 10 10 10 10 10 1	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	-		ins Applied
<u>5</u>	Hygier Hygier ther ti			Elect	rical Engineer		hysics Lal	0
_	m = 0 8	Be	17. Father's Name (First, Middle, Last)	Con		ame (First, Middle, M	a <i>iden Suma</i> me)	
<u> </u>	ould be Mental varked o	ပ	Edwin R. Thompson,	_	Pearl			
Maryland	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events.		19a. Informant's Name/Relationship (T) Michael E. Thompso		Ing Address (Street and Number or F			,
o	and fealth im 27		<u>-</u>	20b. Place of Disp	Tonquil Place Be			
Ö	of # It		20a. Method of Disposition  1 Burial 2 Cremation 3 F	Removal from State   cemetery, cre	ematory or other place)		Oc. Location - City or	
Baltimore,	tant:		`4 □Donation 5 □ Other (Specify)	Metropol	litan Crematory 4,	/26/2004 A	lexandria	, Virginia
39	ermit epar npor ny in		21. Signature of Euneral Service Licens		22. Name and Address of Facility Onald V. Boroward	it Funeral	Homo D I	V
	40 = 4 a		Lug TOI	Courself 4	Conald V. Bor ward 400 Powder Mill F	Rd. Beltsv	ille, Mary	land 20705
No.			23a, Part1, Enter the disease, or comp shock heart failure. List only o	lications that causes the death. Do not en	nter the mode of dying, such as cardia	ac or respiratory arres	st,	Interval Between
	hysician		Immediate Cause (Final disease or condition	Sepsis				Onset and Death
100	/Medical		resulting in death)	Due to (or as a consequence of):				
	Examiner		Sequentially list conditions,	Ischemic Colitis				
	o =	Examiner	if any, leading to immediate cause. Enter Underlyin	Due to (or as a consequence of):				
	acute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	Peritenonitis				
, ed,	ate be executed hysician and the burial-transit		1650(III) Last	Due to (or as a consequence of):				
9 (	hysic the b	Ilcal		Pneumon1u				
RG :	ing p e as	Mec	IF FEMALE:					
XO RO	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of del Month	ivery Dey Year
		sic	1 Yes 2 No	4□Pregnant at time of death 5 [ 9□ Unknown	Other (specify)		l lilonar	Doy Tour
J	requires that the de een signed by the a hould be detached f	Phy				DO- Didash		W
Ś	igne bed	by		ntributing to death but not resulting in the u			cco use contribute to	
0	been signature	ted	GI breeding; Rei	nal Failure; Thrombo	ocytopenia	1 Li fes	2 No 3 Pr	obably 4 Unknown
ပ္က		Completed				24a. Was an autopsy	prior to d	topsy findings available completion of cause of
_ `	ate ha	S				performe 1 ☐ Yes 25	ed? death? ZNo 1 ☐ Yes	2 🗆 No
Vitai	Priysictan: The law this certificate has I ral director, page 2 s	Be (	25. Was case referred to medical examiner?			ath (Check only one,		
0	this ca	္	1 ☐ Yes 2X No	Hospital: 1 Monpatient 2 ☐ ER/Outpatie	ont 3 DOA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 □Other (Spec	city)
		on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe how	injury occurred	
20	Attending r death. sctor: After by the fune	catl	2 Accident investigation		M 1 □ Yes 2 □ No			
		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
<b>⊃</b> ¦	to the hospital or within 24 hours afte To the Funeral Dir completely filled in							
	4 hou	edical	29a. Certifier IX Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in	th occurred at the time, date and place	e, and due to the cau	ise(s) and manner as	stated. to the cause(s)
	vithin 24 hours a To the Funeral Completely filled	Med	one)	and manner stated.				
·		-	29b. Signature and title of certifier	nel. 0-10	29c. License number D42580	290	d. Date signed (Month	
	8		1 8 Aug On	no. Altendrag.			April 25	, 2004
			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	, Print)			
			F.S.Aujia, M.D.	5632 Annapolis Road	l, #13 Bladensbur	g, Marylar	d 20710	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	local.			

3# 1-30-1828.

1 hompson bodusts

			State of Marylar	Ce	rtificate of	Death		Date of Dea		04	5327
Physic	ian	Decedent's Name (First, Middle, Las.     MELVIN DONALD	THOMPSON					Month Dril	Day 22, 20	Year	
/Med	ical	4a. Facility Name (If not institution, give			4b. City, Town,	or Location o		тътт	4c. County		11:30 A <sup>M</sup>
Exam	iner	11335 Halethorpe			German		or Boutin		Montg		• • • • • • • • • • • • • • • • • • • •
Production of the Control of	-	5. Sapa (\$0.000 Number 4 6. Se		last birthday)	If Under 1 Year	If Under	24 Hrs. 8.	Date of Birth	1		lace (State or Foreign htry)
Funera Directo		Usual Residence of Decedent	X M 2□F 74		Months Days	Hours		(Month, Da)			nigan
land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limi		
Man,	to	Md. Montgome	ry (	Germant	own						1 ☐ Yes 2X No
Baltimore, Maryland 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show any injurye other traumatic event, it a Modical Exercitive treather colling and	Director	10e. Street and Number			10f. Zip Code		·····		10g. Citizen of W	hat Coun	ntry?
h wit	a	11335 Halethorpe	Terrace		20	0876		1	United S	tate	S
dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Ori	gin? (Specify	y Yes or No- an, etc.)	14. Race Black	- Americ	ean Indian, etc.
or ft	F	1 Never Married 2 Married	1 Yes 2 □ No		1 ☐ Yes 2X No					Whi	
Dours Line .	d by	3 Widowed 4 Divorced	Year or Dates: WW.								
72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de c <i>ompleted)</i>	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	ipation e <i>during</i> mosi ed)	t of working		16b. Kind of Bu	siness/Ind	dustry
Maryland 21213-UU30 d2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked othar than "natural", or traumatic event, Ita Madical Expri	E G	Elementary/Secondary (0-12) 12	College (1-4or 5+)		onal Sale				Seed Co	พกสก	v
Hygie har.	ပိ	17. Father's Name (First, Middle, Last)		I KOBIK	JIIGI DGIC	7		irst, Middle,	Maiden Sumami		
and d be antal	o Be	Melvin Thompson				Ess	ie Pet	tit			
mari mari	2	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Stree	t and Numbe	er or Rural R	loute Numbe	r, City or Town,	State, Zip	Code)
Ma d 2 s iff ar 27 ls		Eva Krebs (Com	panion)	11335	Haletho	orne Te	errace	Germa	antown.	Md.	20876
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2		20a. Method of Disposition	20b.	Place of Dispe	osition (Name of matory or other pla		Date	•	20c. Location -		
Se se se se se se se se se se se se se se		1 M Burial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Specify	Hemoval from State / A 1		s Cemete	ry	April 2004	27,	Germanto	own,	Md.
IITIF nit. P artme ortan injur		21. Signature of Funeral Service Licen	·	2	2. Name and Addr	1		and the same	ral Home		
Deg F		Cutu El	hear		O East D						d. 20877
SOUR		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications hat caused the dea							THE PARTY	Approximate
		shock, or heart failure. List only of Immediate Cause (Final	one calls on each line. Atheroscle:								Interval Between Onset and Death Years
Physiciai /Medica	_	disease or condition resulting in death)	a. Due to (or as a conse		arutovas	cular	Disca	.50		- 23	lears
Examine	_		Due to (or as a conse-	quoi 100 01).							
ME AS	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):							
uted	Examiner	Cause (Disease or injury that initiated events									
60, be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):							
760, te be ex ysician e burial	cal		d								
68 tifficat tig phy as th	ed										
I Records, P.O. Box 68/60, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		⊒Ectopic pregnan	cv			23d. Date		*
O. B ne deat the att hed for	Sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown		Other (specify)				Mor	in.	Day Year
P.O. hat the d d by the letached	Į,	9 Unknown									(1, 1)
S, I es tha gned be de	by 6	Part II. Other significant conditions of	ontributing to death but not re	sulting in the t	inderlying cause g	iven in Part I					ne cause of death?
cord w requir been si should	fed					-	[]	1 🗆 Y	'es 2□No	3   P100	ably 4 XJUnknown
as be	Completed							24a. Was autop	sy p	rior to cor	psy findings available impletion of cause of
The The page	HO.							perfor 1 ☐ Yes		eath? □ Yes	2 □ No
Vital F vician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					of Death (C	Check only o	ne)		
of V hysic this ce	2	1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	III 3[] DOA				lence 6 Othe		y)
On C ding P h. After t		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	ork?		d. Describe h	ow injury occurre	∍d	
VISION Of VITA Attending Physician: r death. sector: After this certifica by the funeral director.	catl	2 Accident investigation 3 Suicide 6 Could not be				∏Yes 2□					
Division of Vital Records, I or Attending Physician: The law requires after death.  Director: After this certificate has been signs in by the funeral director, page 2 should be	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, tarm, st ify)	reet, factory, office	Ð	281	City or Tou	Street and Numbern, State)	r or Hura	i Houte Number,
Dital of urs all or all Defined in						.:	ed alaka ana	d alors de disco			
Division of Vital Reform to the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Medical		ysicien: To the best of my kn niner: On the basis of examin and manner stated.								
To the within 2. To the complet	Me	29b. Signature and title of ertifier			29c. Licer	nse number		:	29d. Date signed	(Month,	Day, Year)
		1 Xt	1 John 1	~/	D 20	148			April 2	3, 20	004
10		30. Name and address of person who	completed cause of death (Ite	om 23a) (Tyne					-		
		Dr. Steven Dolins				aither	rsburg	, Md.	20877		
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 4	Span	h			-		
Regi	trar	APR 272	004 Dener	10	Paground						

		1 - For State Registrar	te of Maryland	l / Depa <i>Cer</i>	irtment of H	lealth and M <i>Death</i>		iene 200	4 15328
Physic		Decedent's Name (First, Middle, Last)     SARA JANE WE	STROD				2. Date of Deat Month May	Day Year	
/Medi Examir		4a. Facility Name (If not institution, give street a Union Hospital	nd number)		Elkton	r Location of Death	<u> </u>	4c. County of De	
Funeral Director		5. Social Security Number 222-24-4489 6. Sex 1 ☐ M 2 Usual Residence of Decedent	7. Age (In yrs. Ia 64	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9 – 5 – 1	9. B 939 De	irthplece (State or Foreign Country) Laware
death with the Maryland ms 23a or 28a-f show rinust to cotfilled at	tor	10a. State 10b. County Delaware New Castl		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
with the	Director	10e. Street and Number 4820 Summit Bridg	e Rd		10f. Zip Code	n 9	1	0g. Citizen of What (	Country?
Id yidild XIX ID-0030 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show eumatic event, It a Medical Examinar mout by confiled at	by Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S ned Forces? 1/Yes 2/3/No es, Give ar or Dates:	į .	Vas Decedeni of H Yes, specify Cuba	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
within 72 houene.	Completed	15. Decedent's Education (Specify only highest grade comp		(Give life. L	lent's Usual Occup kind of work done of DO NOT use retired Store	during most of work: d)	ing	16b. Kind of Busines	ŕ
VIGITIO A	To Be Co	17. Father's Name (First, Middle, Last) Arlington Lloyd				18. Mother's Name	White		
and and lealth m 27 her tr		19a. Informant's Name/Relationship (Type, Prince Robert J. Westrod 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	20h Bla	482	0 Summi	t Bridge	e Rd.,M	; City or Town, State, Iiddletov 20c. Localion - City o Smyrna, [	n, DE.19709
DESILLIMORE  permit. Pages 1 Department of H Important: If ite any injury or ot	1	Signature of Funeral Service License	A	22	. Name and Addres	ss of Facility DAN	NIELS &	HUTCHIS	SON 1,DE,19709
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	me to for as a conseque	so not ente	er the mode of dyin	g, such as cardiac o	or respiratory arre		Approximate Interval Between Onset and Death
certificate be executed certificate be executed conding physician and use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a conseque						
BOX of auth certif	hysician/Medi	in the past 12 months?	es, outcome of pregnan  Live birth 2	death 3	Ectopic pregnancy Other (specify)			23d. Date of d	elivery Day Year
cords, F.O. wrequires that the deben signed by the should be detached	by P	Part II. Other significant conditions contributing	g to death but not resul	ting in the ur	nderlying cause give	en in Part I.	23e. Did tob		o the cause of death? Probably 4 Unknown
The larate has	Completed						24a. Was an autops perform	y prior to death?	
Attending Physician: The result.  * death.  * ector: After this certificate by the funeral director, page	ertification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	1 Impatient 2 E	R/Outpatien 28b. Time of Injury	28c. Injun Worl	y at	me 5 Reside	e) ince 6  Other ( <i>Sp</i> w injury occurred	ecify)
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	O	3 Suicide 6 Could not be 4 Homicide determined 28e	Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or F , State)	Rural Route Number,
To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physicien: 2 Medicel Exeminer: Or an							
To t To t com	Σ	29b. Signature and title of certifier	festad		29c. License	e number	3	9d. Date signed (Mor	04
6		30. Name and address of person who complete Martha Hosbard-	d cause of death (Item :	23a) (Type, 1	Print) /// W.	Hich St	#104	EIKH	on, MO 2192
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 4 2004	32: Registrar's Signatu	ire A	soften o	0			

sician	•	For State Registrar		•	ertificate of Deatl	and Mental	Reg. No	2001	15320
sician		Decedent's Name (First, Middle, Last			F. 7.7 (12.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7	2. Date of		ay Year	3. Time of Death
edical			ELDON	DAVID	WAGNER	APR	11		6:10 A M
miner	4 -	Facility Name (If not institution, give	street and number)		4b. City, Town, or Location	of Death	40	. County of Death	
	2	551 BALTIMORE		58	FINKSBUT			CARROL	
ral		Social Security Number 6. Se	ox 7. Age ⊋M 2□F	e (In yrs. last birthda 7 G Yrs.	Months Days Hours	Min. 8. Date of Monty	of Birth 7, Day, Year 1927	9. Birth	place (State or Foreign ntry)
tor	-	14-22-7167   ** sual Residence of Decedent	2	76 Yrs.		9/3/	1927	MAR	ZLAND
	-	a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
į		MD. CARROI	i.T.	FINKS	BURG				1 ☐ Yes 2 🖾 No
-uneral Director	10	e. Street and Number			10f. Zip Code		10g. C	itizen of What Cou	ntry?
0	2	551 BALTIMORE	RTVD.	58	21048		US	A	
Funeral	11	. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S. 1:	3. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	rigin? (Specify Yes	r No-	14. Race - Ameri Black, White,	
		1 Never Married 2 Married	1 ∑XYes 2 □ N If Yes, Give	6 1945	1 ☐ Yes 2 ☒ No Specif		.,		IITE
À		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1946	100 200 NO			Specify. 94.	11.11
Completed		15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. De (Gi	cedent's Usual Occupation ve kind of work done during mo b. DO NOT use retired)	st of working	16b. I	Kind of Business/Ir	dustry
Q E		Elementary/Secondary (0-12)	College (1-4or 5	+)	o. DO NOT use retired) SALE		7/ 1/1	OMOBILI	~~ ~~
		1.2 '. Father's Name (First, Middle, Last)		<u>l</u>		ner's Name (First, M.			1
Be	i		RLES A.	WAGNER			GOBRI		
ျ		9a. Informant's Name/Relationship (T)			illing Address (Street and Num	has as Russ / Rauta N	umbar City	or Tourn State 7	Codel = 1 = 1 =
		9a. Informant's Name/Helationship (7) OORIS WAGNER	урө, Рат) — WII		1 BALTIMORE				
	-	Da. Method of Disposition				Date		ocation - City or T	
	20	1 ☐ Burial 2. ☐ Cremation 3 ☐ F		cemetery, c	position (Name of rematory or other place)				
		'4 □Donation 5 □ Other (Specify)		Add Coo			_		
SUCE.	2	1. Lignatu a o Funs II Service Licens	100		22. Name and Address of Fac				
_	+-		lications that assessed		254 T. MAIN			· 3 L. I. C. 13	D. 21157 Approximate
		3a. Part1. Exter the disease, or comp shock, of heart failure. List only o	ne cause on each lin	10.	sinter the mode of dying, such a	s cardiac or respirati	ny arrest,		Interval Between Onset and Death
at	d	nmediate Cause (Final isease or condition esulting in death)	a		lerotic CAZ	o lo cosci	sicce s	Solove	THEM
ı	1	f	Due to (or as	a consequence of):					
<u>.</u>	S	equentially list conditions,							
_ <u>2</u>	c	any, leading to immediate ause. Enter Underlying ause (Disease or injury							
Examin	th re	aat initiated events esulting in death) Last	Due to (or as	a consequence of):					
			d						
2		•							
2		F FEMALE:	23c. If yes, outcome					23d. Date of deliv	ery
<u>e</u>		3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	ery Day Year
2		3b. Was decedent pregnant	1☐Live birth	2 Fetal death			_		-
Physician/Medical	1F 2:	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown  ontributing to death be	2 ☐ Fetal death time of death time of death ut not resulting in the	5 Other (specify)	I. 23e.	Did tobacco	Month	-
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			1 = For State Registrar	State	of Maryla	ind / Depa <i>Cei</i>	artment rtificate	of He	ealth and <i>eath</i>	Mental Hy	/giene Reg. No	20	04	15330
4	Dhysiair		Decedent's Name (First, Middle, La	st)						2. Date of D Month			'ear	3. Time of Death
	Physicia /Medic		Hwa-Chua		Wang					Apri1	24		04	3:00 A. <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, giv		number)				ocation of Dea	ith	40	County of		
2	Euperal	* ct	18101 Hayloft Dri 5. Social Security Number 6. S		7. Age (In yr	s. last birthday)	If Under 1	Year	ville If Under 24 Hr		rth	Monte	). Birthp	ace (State or Foreign
	Funeral Director			I□M 2 <b>X</b> F		78 Yrs.	Months	Days	Hours Mir	Dec. 2	ay, Year,	, ,	Coun	ina
	Ď ,		Usual Residence of Decedent  10a, State 10b, County		100.0	City, Town or Lo	antina			•			141	0d. Inside City Limits
	faryla shov	2	,			•							''	1 ☐ Yes 2 ☑ No
	the N	Director	Maryland Montgom	ery		Rockvil:	Le 10f. Zip C	Code			10a. Ci	tizen of Wh	at Coun	
	death with the Maryland ms 23a or 28e-f show must be notified at		18101 Hayloft Dri	170				0855				ited		,
	death	Funeral	11. Marital Status		cedent Ever in	U.S. 13.			panic Origin? (	Specify Yes or N rto Rican, etc.)		14. Race -		an Indian,
0	or Ite		1 Never Married 2 Marned		2 🔀 No		1  Yes 2		Specify:	no moan, etc.)		Specify:	vviiite, t	ac.
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<u>.</u>	in 72 in mat	Completed	15. Decedent's E (Specify only highest gra	ade completed		(Give	dent's Usual ( kind of work DO NOT use	done du retired)	ring most of w	orking	160. K	(ind of Busin	ness/ind	lustry
7	s with	Eo	Elementary/Secondary (0-12)		(1-4or 5+)		Teache				Jr	. High	h Sc	hoo1
<u> </u>	al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last	)				1	8. Mother's Na	me (First, Middle	, Maider	Sumame)		
yland	Menta Menta arked arlc a	ToE	Hsueh-Wa	i Lu	11					Chen-	Shih	L	u	
Mar	2 sho and is m		19a. Informant's Name/Relationship (	•						Rural Route Numb				
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Any injury or other traumatic avent, the Modical Examinar must be notified at once.		Chin-Yuan Derek W 20a. Method of Disposition	ang/Sor		18101 Place of Dispo			Drive,	Rockvill		(aryla ocation - Ci		
5	ages F: Fire		1 ⊠ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special		m State	cemetery, cren	•		1	/26/2004			•	
ашто	nit. P artme orten injur		21. Signature of Funeral Service Lice		م (ا	^	Name and			eVol Fur	_		-	ng, rib.
ñ	Deg Per		Muelen		وكلييل	Lu 10	East	Dee		Dr., Gai				D. 20877
ž.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	t caused the de	ath. Do not ent	er the mode	of dying,	such as cardia	c or respiratory a	rrest,			Approximate Interval Between
, f	nysician		Immediate Cause (Final disease or condition	, Cer	ebral V	/ascular	Accid	dent						Onset and Death  8 years
	/Medical Examiner		resulting in death)	Due t	o (or as a cons	equence of):								
	_xaiiiiic.	2	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or as a cons	equence of):							-	
	nsit	Examine	Cause (Disease or injury		0 (0, 40 4 00.10									
ĵ	exect an and rial-tra	Exa	that initiated events resulting in death) Last	C. Due to	o (or as a cons	equence of);							-	
00/8	certificate be executed Iding physician and Ise as the burial-transit	dical	(	_ d			·							
٥	artifica ing ph e as th	Med	IF FEMALE:										1	
XOD	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🗀 Live	outcome of preg	etal death 3	Ectopic preg					23d. Date o Month		y Day Year
	the de	ysic	1 Tes 2X No 9 Unknown	9 Unk	gnant at time of snown	rdeath 5L	Other (spec	:my)						
ŗ.	requires that the een signed by th hould be detache		Part II. Other significant conditions	contributing to	death but not re	esulting in the ur	nderlying cau	ise given	in Part I.	23e. Did	tobacco	use contribu	ute Io the	e cause of death?
ecords,	quires in sign	q pe	Hypercholestolem	ia						1 🗆	Yes 2	□ No 3[	☐ Proba	ably 4 ⊠Unknown
ပ္သ	aw re	plet								24a. Was		24b. Wei	re autop	sy findings available
ב	The law rate has be page 2 sh	Completed by	1							auto perfe 1 ☐ Yes	psy ormed? 2⊠ No	dea	th?	pletion of cause of
	oding Physician: The law th. : After this certificate has b i funeral director, page 2 s	Be	25. Was case referred to medical examiner?							ath (Check only	one)			
5	shysion this on	၉	1 ☐ Yes 2 ☒ No			ER/Outpatien			4   INUISING	Home 5 X Res			(Specity	)
ום	ding I	Ilon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		e of Injury onth, Day Year)	28b. Time of Injury	M 280	Work?	ıt ıs 2∐No	28d. Describe	now injui	ry occurrea		
DIVISION	Attended death ctor: y the	fica	3 Suicide 6 Could not b	e 28e. Pla	ce of Injury - At	home, farm, stre				28f. Location (	Street an	nd Number o	or Rural	Route Number,
	al or / s after if Dire	Certification:	4 Homicide	buil	lding, etc. (Spe	cify)				City or To	wn, State	9)		
	To the Hospital or Attending Physicien: within 24 hours after death To the Funeral Director: After this certification is a properly filled in by the funeral director, the	edical (	29a. Certifier 1 Certifying Pt (Check only one) 2 Medicel Exer	niner: On the										
	o the o the o the omple	Med	29b. Signature and title of certifier	and ma	inio Stated.		29c. L	License r	number		29d. Da	te signed (A	Month, D	Day, Year)
	- 3 5		It alsio	1.	2 ~		T.	) 3 4	1969		17:	N- 26	4	2004
	_	-	30. Name and address of person who	completed ca	use of death (It	em 23a) (Type,	Print)		( - /		10	, -	1 7	) Des
			H Victor Chia	rc. ini		7 17ed:	ral ce	ente	- Br.	Suite 3	20 /	Ruder	16	2004 mn 20850
- 1	Sta	te ar	31. Date filed (Month, Day, Year) APR 2 7 20	32.	Registrar's Sig	nature 4	dra.	1/2	,					

04-26 B.K.S	64 Robe	ert	Lee Williams, Jr. Please	Type or Pri	nt in Black	( Indelible	Ink. Ensure A	All Copies	Are Legible.	
UNKNO	WN 04-1	33	- State Unpend Item Registrar	State of M #23a,27,2	aryland/D 28a-f per	epartment C <b>ertificate</b>	of Health and	Mental Hyo s	giene Reg. No 2004	15331
	Physici	an	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month		3. Time of Death
	/Medic	al.	Robert L 4a. Facility Name (If not institution, give				own, or Location of Deat	APRIL	17, 2004 4c. County of Dea	2314 Рм
-	Examin	er	PRINCE GEORGES H				ERLY	''	PRINCE G	
301	Funeral Director		310-30-0430	ex 7. A( ▼ M 2□ F	ge (In yrs. last birtl 49 Y		Year If Under 24 Hrs Days Hours Min.		r, Year) C	rthplace (State or Foreign ountry)
, ,	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Man Je-f sh Liffied	ctor	D.C. N/A		Wash	ington				XX Yes 2 □ No
	death with the Maryland ms 23s or 28e-f show	Director	10e. Street and Number 753 Quebec	Place	N W	10f. Zip C	ode 0010		10g. Citizen of What C	
	ms 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.		nt of Hispanic Origin? (S y Cuban, Mexican, Puer	Specify Yes or No-	U.S.A.	erican Indian,
036	ours after ral', or ite	by	X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces'  1  Yes 2  If Yes, Give  Year or Dates:		ir Yes, specing		to Hican, etc.)		Black
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ite Medical Examination to confiled an once.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or			done during most of wor retired)	rking	16b. Kind of Business Private	s/Industry
9	filed v Hygie other t		12th 17. Father's Name (First, Middle, Last)			Constru		me (First, Middle,		
ılan	uld be Aental rked c	To Be	Robert Lee	William	s, Sr.		Ruby	Ann Mor	ntgomery	
lary	2 short and N ls ma		19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Address (	Street and Number or Ru	ural Route Numbe	r, City or Town, State,	Zip Code)
altimore, N	ts 1 and of Health item 27 other to	1 1	Diane Richardso 20a. Method of Disposition	•	20b. Place of	27 Hann Disposition (Name o, crematory or other	a Pl. SE	D.C.	20019 20c. Location - City o	r Town, State
im	Page ment of uny or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	y)				5/1/04	Mt. Ve	rnon, Ill.
Balt	Departi Departi Import any inj once		21. Signature of Funeral Service Licer	10 100	ened	The	Address of Facility House of			
•	Physician /Medical Examiner	955	23a Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each I a Due to (or as	ine.	ltiple In		c or respiratory arr	est, • • •	Approximate Interval Between Onset and Death
, 0,	e executed ian and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	С.	s a consequence o					
876	cate b ohysic the bi	dica		d						
Division of Vital Records, P.O. Box 68760,	Attanding Physicien: The law requires that the death certificate be exerdeath.  death.  ector: After this certificate has been signed by the attending physician a py the funeral director, page 2 should be detached for use as the burial-in	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		e of pregnancy 2 Fetal death at time of death	3 ☐ Ectopic preg 5 ☐ Other (spec			23d. Date of de Month	elivery Day Year
S. P.	ires that t signed by I be detail	by	Part II. Other significant conditions of	ontributing to death I	but not resulting in	the underlying cau	se given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
Sor	w requir been si should	letec						24a. Was a	/	utopsy findings available
Re	The lav ate has page 2	Completed			<del></del>			autops perform	sy prior to med? death?	completion of cause of
/ita	iiclen: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	Manadal				ath (Check only or	18)	
of	Physi this c	To.	1XXYes 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpati		patient 3 DOA	Other: 4 Nursing F	lome 5 Reside	ence 6 Other (Spe	ecity)
lo	nding l ath. r: After e funer	atlon	1 □Natural 5 □Pending investigation	28a. Date of Inju (Month, Da 4/17/04	ay Year) In	2.896	: Injury at Work? 1 □ Yes 2 ¶ No	Subject by vehic	was pedest	rian struck
Divis	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined		jury - At home, far tc. (Specify)		office	28f. Location (St City or Town	treet and Number or A n. State) 40th S St., Washi	treet@ E.
	Hospit 24 hour Funere stely fille	edical (	29a. Certifier 1 ☐ Certifying Ph (Check only one)	nysician: To the best niner: On the basis of and manner si	of examination and	death occurred at /or investigation, in	the time, date and place my opinion, death occu	, and due to the c	ause(s) and manner a	s stated.
	To the within To the Comple	Me	29b. Signature and title of certifie	In.	M		icense number O.C.M.E			, 2004
	2		30. Name and address of person who	complete calse of	death (Item 23a) (	Penn Stre	et, Baltimo	ore, Mary	land 21201	
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 6 20		rar's Signature	Spon	ks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 15332 Amend Items 24a,25,26,27,29a per Dr., C831,05/27/Center Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2004 **Physician** Charles 13, Apr. R Wagner 10:20pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Devlin Manor Nursing Home If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1**∑**M 2□ F 213-22-3269 Director Jun 9, 1926 MD Usual Residence of Decedent death with the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be middled at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10e Street end Number 10f. Zin Code 10g. Citizen of What Country? 12D Wempe Drive 21502 USA Funeral 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural; or ite any highly or other traumatic event, the Medical Expansion 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No 3altimore, Maryland 21215-0020 Specify: ģ 3 Widowed 4 Divorced white WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred E. Wagner Alice Beryl (Ganoe) Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettie Wagner 3209 Bethesda Drive wife Waldorf MD 20601 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 4/16/2004 4 ☐ Donation 5 ☐ Other (Specify) Cumberland MD 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service License 108 Virginia Avenue; Cumberland, MD 21502 23a. Paryl. Enter the disease, or complications that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Wedwal Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner certificate be executed attending physician and for use es the buriel-tr nsit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last ed by the at deteched for Part II. After significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signed the should be detected Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗆 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital
within 24 hours e
To the Funeral C Medicai 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54411 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso

32. Registrar's Signature 900 Memorial Ave Ste 105 Cumberland MD 21502

Registrar

State

Beverly Calkins M.D.

State of Maryland / Department of Health and Mental Hygiene State RegistrAMEND TIEM #8 PER FH C831 5/14/04 JH Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** HERENIA M. WALDHAUSER APRTI. 30 2004 0335 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CORSICA HILLS NURSING HOME CENTREVILLE QUEEN ANNE'S If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 2-05-1910. Birthplece (State or Foreign (Month, Day, Peal) 5. Social Security Number **Funeral** Months 1 □ M 2 🔽 F Director 215-09-1292 MDUsual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthan "natural", or iteme 23a or 28a-f show the Modest Examiner must be notified at Yes 2 No Director QUEEN ANNE'S CENTREVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 205 ARMSTRONG AVENUE 21617 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education ify only highest grade completed) 16b. Kind of Business/Industry (Specify only highest grade other than Elementary/Secondary (0-12) College (1-4or 5+) -Õ-**TAILOR** CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event Be KILLIAN WALDHAUSER ANNIE MAY BORGMANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 TERRAPIN GROVE, STEVENSVILLE, MD ANNA MAY ELLINGER / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State CHESAPEAKE CREMATORY 5/06/2004 \* 4 Donation 5 Dother (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. once 106 SHAMROCK ROAD, CHESTER, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition menner 14 Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9□ Unknown 9 Unknown à peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 3473 1 Yes 2□ No 1 ☐ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation or Attending 14 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif 4/30 10 4 30. Name and address of person wno completed cause of death (Item 23a) (Type, Print) de 7108 DI Doverpo mode 32. Registrar's Signature 31. Date filed (Month) State 2004 Registrar 1. South

		1 - For State Registrar	State of N	Marylan		artment of H		nd Mental Hy	Reg. No. 2	004	15334
Physic /Medi	ν.	1. Decedent's Name (First, Midd Alta	Marie		Zembov			2. Date of De Month May	1, 2004		3. Time of Death  3:45 am
Examir	ner	4a. Facility Name (If not institution Sacred Heart		r)		4b. City, Town, or Cumbe		Death	Alle	y of Death Danv	
Funeral Director		5. Social Security Number 212-12-8208		Age (In yrs. 95	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, Di Feb S			ace (State or Foreign ny) VV
Maryland -f show	tor	10a, State MD All	egany	10c. Cit	y, Town or Lo	nberland					d. Inside City Limits
with the	Funeral Director	10e. Street and Number 411 Columbia	Street			10f. Zip Code	21502		10g. Citizen of	What Count	ry?
21215-0036  3 within 72 hours after death with the Maryland piene. 1 than "natural", or Items 23s or 28s-f show tr than "natural", or Items 23s or 28s-f show the Medical Examiner rount be notified at	þ	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	If Voe Give	s? ⊃X <sup>N</sup> o		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin n, Mexican, I Specify:	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Ra Bla Speci	ice - America ack, White, e	tc.
21215-0036 ad within 72 hours af gigiene. er than "naturel", or the Medical Exam.	Completed		ont's Education est grade completed) College (1-4c	r 5+)	(Give	dent's Usual Occup: kind of work done on DO NOT use retired	ation during most o	of working	16b. Kind of E		ıstry
land 2 uld be filed fental Hygir rked other	To Be C	17. Father's Name (First, Middle Thomas Ro						s Name (First, Middle y Belle (Co			ırg
iore, Maryland 2 ges 1 and 2 should be filed to of Health and Mental Hyg if item 27 is marked othe or other traumatic event,	8	19a. Informant's Name/Relation Jack McNeill	nship (Type, Print) SOT	1	19b. Maili 670	ng Address (Street a )5 Lehigh /	Avenue	or Rural Route Numb B Harr	er, City or Town isburg	n, State, Zip ( PA	
E E E E		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other			nset Me	osition (Name of matory or other place morial Park		Date 5/4/2004	Odiffic	- City or Tow perland	
Balti permit. Departr Importa any inji		21. Signature of Funeral Service	7 200	ginia Av	al Home, PA enue: Cumbe	erland, MI					
Physician / Medical Examiner physicien and physicien and the printial-transit	dical Examiner	23a. Part1. Efter the disease, shock, or heart failure. List Immediate use (Final disease or notition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a c.	VEL IN as a conseq	FARCTI juence of): MBOLIC juence of):		g, 3001 <b>a</b> 3 cc	and a street of the street of			Approximate Interval Between Onset and Death 24 hrs.
O.O. Box 68' at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	ıl death 3[	□Ectopic pregnancy □ Other <i>(specify)</i>	,			ate of deliver	y Day Year
Records, P.O. The law requires that the ste has been signed by th page 2 should be detache	٥	Part II. Other significant condi	-	but not res	sulting in the u	inderlying cause giv	en in Part I.	1			e cause of death?
	Completed		==							prior to com death?	sy findings available apletion of cause of
of Vital F Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medic examiner?  1 Yes  No	Hospital:	atient 2	] ER/Outpatie	nt 3 DOA Oth	000	of Death (Check only sing Home 5 ☐ Res		ther (Specify	)
P Py Printer	I	27. Manner of Death 13€ Natural 5 ☐ Pend	28a. Date of It	THE PARTY OF THE P	28b. Time o Injury	of 28c. Injur Wor		28d. Describe	how injury occu		
in Little	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	minord 289. Place of	Injury - At h etc. (Specil	ome, farm, st fy)	reet, factory, office			(Street and Nun own, State)	nber or Rural	Route Number,
Divi	Medical	(Check only 2 Medic	ring Physician: To the be al Examiner: On the basis and marner	s of examina	owledge, dea ation and/or in	nvestigation, in my o	pinion, death	place, and due to the occurred at the time	e cause(s) and n , date and place 29d. Date sign	, and due to	the cause(s)
To with To con	2	10-400	ws		w		3/,	50	5-5		
4		30. Name and address of person Michael	on who completed cause of Stasko, MD				umberl	and, MD 21	1502		
Si Regis	ate trar	31. Date filed (Month, Day, Yea	AY 1 2 2004	etror's dian	aturo	1 Speck					

04-03226 JEAN ATKINSON WHM

unpend item#23a,Part II,27,PER ME,C832,6/24/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician   Medical Examines   Activities on JEAN E. ATKINSOW   March   Activity Name   March   Activity Name   March   Activity Name   March   Activity Name   N	1533
Security Name of Productions, give series and number)   Sec. City. Town, or Location of Death   N/A	. Time of Death 14:50 M
Use Readonce of Decedent   10c. City, Town or Location   10d. To Code   10c. City, Town or Location   10d. To Code   10d. County   10d. Special   10d. County   10d. To Code   10d. County   10d. To Code   10d. County   10d. City Code   10d. County   10d. City Code   10d. County   10d. City Code   10d. Co	
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   17. Dorothy Wynn   17. Dorothy W	nsylvani Inside City Limits
Transfer Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   18. Mother's Name	1 □ Yes 2 <del>Q</del> No
Transfer Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   18. Mother's Name	
23a. Part 1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Physician	ry
23a. Part 1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Physician	
23a. Part 1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Physician	
23a. Part I. Elime the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Physician	D
Immediate Cause (Final death)   Immediate Cause (Final death	ome 1237 proximate
FEMALE:   23d. Date of delivery   23d. Date of deliv	
25. Was case referred to medical examiner? 1 1X Yes 2 No	Year
25. Was case referred to medical examiner?  1 X Yes 2 No	
25. Was case referred to medical examiner?  1 X Yes 2 No	findings available tion of cause of No
C 2 1 Matural 5 Pending (Month, Day Year) Injury Work?  Injury Work?  Injury Work?  Injury S 2 No	
To the design of the determined street factory of the determined s	ute Number,
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (Month, Day, one)  29c. License number (29d. Date signed (Month, Day, one))	cause(s)
Thoday M. Kengaras OCME MAY 13, 2004	Year)
30. Name and address of person who completed case of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Marylar  State Registrar  MAY 1 3 2004  MAY 1 3 2004	xd 21201

MAY 1 3 2004

State of Maryland / Department of Health and Mental Hygiene State Amend item 11 per inf g835 9-Dertificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year 0643AM **Physician** 2004 Brown Mae Dora /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Good Samaritan Hosp. Baltimore NA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 25 F Yrs. 53 N.C 217-56-7528 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show event, the Mudical Exeminer must be notified at 1 XYes 2 ☐ No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt. 3-B 4003 White Ave. 21206 USA or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ▼ No Specify: Maryland 21215-0036 Specify: þ Black 3 ☐ Widowed 4 ☐ Diverced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Varies Private Duty Nursing

18. Mother's Name (First, Middle, Maiden Sumarne) 12th grade 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should bit Department of Health and Menia Importent: If Item 27 Is marked eny injury or other traumatic even Coppage Otis Arlene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21206 Rhonda Chase Brown Daug-in-law 3507 Royston Ave., Baltimore, Md. more. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐ Removal from State 5-17-04 Voshell Mem. Pk. Dundalk, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 1101 E. North Ave. 23a. Part1. Enter the disease, or conficiations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. March F.H. East Approximate Interval Between Onset and Death Immediate Cause (Final Asthma Exacebation **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Tobacco Abuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , age 2 performe 1 Tes 1 ☐ Yes 2 X No certificate 2 No Vital To the Hospitel or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 NOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 6 this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No de ath. investigation within 24 hours after death To the Funerel Diractor: 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) in by determined 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0059388 Leisman-Internal Medicite 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raver Blud. Lussell Morgon Building Suik 500, Baltimor MD

31. Date light Month, Pay, Year) 32, Registrar's Signature Society

State Registrar

		•	1 - For State of Maryland / Departme Certifica	nt of Health and Me te of Death	ntal Hygie	C004 10001
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  Tear M. Beall		Date of Death Month	Day Year 3. Time of Death 4 2004 0930
	Examin Funeral Director		120 5th Avenue, S.E. G	y, Town, or Location of Death  BUCK  er 1 Year If Under 24 Hrs. Days Hours Min.	Date of Birth (Month, Day, Ye 09/22/19	4c. County of Death  9. Birthplece (State or Foreign Country)  49 Minnesota
t.	aryland ehow	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arunde1 Glen Burnic			10d. Inside City Limits 1 ☑ Yes 2 □ No
	ath with the Marylan 23s or 28s-f show	Funeral Director	10e. Street and Number 10f. 2	ip Code	10g.	Citizen of What Country?
036	hours after death with the Maryland turel , or items 23s or 28s-f ehow at Exertiret nast be redified at	þ	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ▼Never Married 2 Married 1 ↑ Yes 2 ▼No	edent of Hispanic Origin? (Specificerify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	"na	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Iife. DO NOT Customer	vork done during most of working use retired)  Service Represe	Fo entative	
Maryland	should be filed within nd Mental Hygiene. i marked other then amatic event, the M	To Be	17. Father's Name (First, Middle, Last)  Ardell Anderson  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addre	18. Mother's Name (F  Lois Erie ss (Street and Number or Rural F	e	
altimore, Ma	jes 1 and 2 s of Health ar if item 27 is or other trau		Steven Joseph Beall, Son 7916 Goug  20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (No cemetery, crematory or	gh Street, Balt	imore, M	
Baltin	permit. Peg Department importent: any injury o		1 1110 Stayout 401228	and Address of Facility Flew Sandy Spring Roa	ck Funer ad, Laur	al Home, Inc. el, Maryland 20707 Approximate
8760,	Physician /Medical Examiner  per per per per per per per per per per	licai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Dist	PAS Conset and Death
O. Box 6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as if	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (			23d. Date of delivery Month Day Year
rds, P.	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobace	co use contribute to the cause of death?
al Record		Completed			24a. Was an autopsy performed	
Division of Vital	ding Phy I. After this funeral d	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	28c. Injury at Work? 1   Yes 2   No	5 Residence d. Describe how i	
DİXİ	spital or Ati ours after d seral Direct filled in by		28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)  29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred		City or Town, S	
)	To the Hospital or Attance, within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one)  20 Medical Examiner: On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier	on, in my opinion, death occurred 9c. License number	at the time, date	and place, and due to the cause(s)  Date signed (Month, Day, Year)
_	6			095 Am	erica	5/5/4
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 3 2004  Registrar's Signature			

		-	For State Registrar		State of Ma	aryland /	Departi Certif	ment of F icate of i	lealth a <i>Death</i>	and Menta	al Hygien Reg. Ne		15338
Phys /Me		n	1. Decedent's Name		si) Oltz						te of Death		3. Time of Death  2:30 PM
Exan Funer Directo	nine ral	er	FRANKI 5. Social Security No 097-16-	umber 6. S	TO	Spilal e (In yrs. last 81	birthday) If	City, Town, on Rose Cunder 1 Year on this Days	1 1	of Death	te of Birth	BAITI	MORE hplace (State or Foreign
yland	86	-	Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	own or Location	on					10d. Inside City Limits
he Mar 8e-f st		ector	Maryland	Baltimo	ore			ltimore					1 □ Yes 2 □ No
with th		בוֹם	10e. Street and Nun 5330 Ca.	<sub>nber</sub> stle Stov	10 Drivo		1	0f. Zip Code	2123	7	10g. Ci	itizen of What Co	,
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Importent: If item 27 is marked other than "naturel", or iteme 23a or 28e-1 show any injury or other treumetic event. The Modital Examinar must be restilled.		by Fur	11. Marital Status	ed 2 Married	12. Was Decedent Armed Forces? 1 XYes 2 ☐ I If Yes, Give Year or Dates:			Decedent of H s, specify Cuba Yes 2 X No		gin? (Specify Ye , Puerto Rican,	es or No- etc.)	14. Race - Ame Black, Whit	ncan Indian,
15-0 72 ho natur		leted	(Spec	15. Decedent's Ed	ducation de completed)	16	(Give kind	s Usual Occup of work done	durina most	of working		Kind of Business	
2121 d within giene.		Completed	Elementary/Second 12th Gran	ndary (0-12) de	College (1-4or 5	i+)		VOT use retired Ttist	3)			lf-Empl tist	oyed
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other than "naturel", or treumatic event. The Martical Exam		Be	17. Father's Name (								Middle, Maide	n Sumame)	
should by Men marka		<u>o</u>	John 19a. Informant's Na	Boltz ame/Relationship (	Type, Print)	1	9b. Mailing A	dress (Street			Schelme	.yer. or Town, State, 2	Zin Code)
, Ma end 2 saith ar n 27 is er treu			Mrs. Kar		(daught						Baltimo		21237
Baltimore, bermit. Pages 1 er Department of Hea mportent: If item iny injury or othe			20a. Method of Disp 1 Burial 2 2 4 Donation 21. Signature of Fu	Cremation 3 5 Other (Specif		ceme	iew Cr	ry or other plac 2 <b>matory</b>		Date 5/12/04	Bal	ocation City or timore, eral Hor	Maryland
Department	once		1/2	1813	alani	1						MD 21236	
Fnysicia /Medic: Examine	ai er	Examiner	23a. Part. Enter it spock, or hear it spock, or hear immediate Cause (disease or condition resulting in death)  Sequentially list configure. Enter Under Cause (Disease or that initiated events resulting in death) It.	Final n n n n n n n n n n n n n n n n n n	a. A Due to (or as  b. Due to (or as  Due to (or as	a consequence	fve of):	e mode of dyin	,	cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
Records, P.O. Box 68760,  The law requires that the death certificate be executed at has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	:	Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	t pregnant months?	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	of pregnancy	ath 3⊟Ect	opic pregnancy eer (specify)				23d. Date of del Month	vêry Day Year
rdS, P quires that n signed b	Ι.	2	Part II. Other signifi 州ソののメごれ		ontributing to death b	ut not resulting	g in the under	ying cause give	en in Part I.	23			the cause of death?
VItal Records, P.O. sicien: The law requires that the di certificate has been signed by the rector, page 2 should be detached		Completed	HTN, Perinh	Chron ERAL V	ASCULAR	Dise	'ASC				a. Was an autopsy performed? Yes 25 No	prior to death?	topsy findings available completion of cause of 2 No
f Vit ysicie is certii directo	1	0	25. Was case referr examiner? 1 ☐ Yes 2 ☐		Hospital: 1 Inpatie	nt 2 ER/	Outpatient 3	□ DOA Othe	00	of Death (Chec sing Home 51		6 □Other (Spec	tify)
Division of Vital Rec To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director; After this certificate has completely filled in by the funeral director, page 2	,	Certification: 1	27. Manner of Death 1 Natural 2 Accident	h 5 ☐ Pending investigation 6 ☐ Could not be	28a. Date of Inju (Month, Day	ry Year) 28t	Time of Injury	28c. Injury Work		28d. De	escribe how inju		,
DIVI			3  Suicide 4  Homicide	determined	building, etc	c. (Specify)		_		City	y or Town, State	9)	ral Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled		ledical									to the cause(s)		
Tor Toor		4-	29b. Signature and	larez	completed cause of d	eath (Item 23s	a) (Type Print	RES	00		5-,	te signed (Mont)	4
Regi	W 1	e r	0- 6-1	th, Day, Year)	32. Registra	eath (Item 23a	Joan Span	N Squ	ARE	DR. 13.	AlTimo	PRE Md	11237

ORIGINAL

Earl O'Bryan 04-03065 RE

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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P.D. 			i - State Amend & Un	pend Item #:	1,23a,2	2 <i>Celtitics</i> ite	ef Dieath		FAISHO.	U4 ———	15339
	Physici	an	1. Decedent's Name (First, Middle, L	Earl Will:	iam Bra	aun, Sr.		2. Date of D Month May 6	, 2004	Year	3. Time of Death 0509 A M
	/Medic Examin	aı -	4a. Facility Name (If not institution, g 819 South Oldham	ive street and number)			wn, or Location			y of Death	
5	Funeral Director		5. Social Security Number 219-90-2804	Sex 7. Age	(In yrs. last b	oirthday) If Under 1 Months E	Year If Under Days Hours	24 Hrs. 8. Date of B	irth 24, 1977	9. Birthp Cour	place (State or Foreign htry) MD.
}	land ow		Usual Residence of Decedent  10a. State  10b. County		10c. City, To	wn or Location				1	10d. Inside City Limits
	the Marylan 28a-f show notified at	ctor	MD. N/	A	BA	LTIMORE					1∭Yes 2☐No
	death with the Maryland rms 23a or 28a-f show Fraust be ricitified at	Funeral Director	10e. Street and Number 819 OLDHAM STREE	ET		10f. Zip C	ode	21224	10g. Citizen of U.S.		ntry?
036	s after ', or Ite	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Deceder If Yes, specify 1 ☐ Yes 2 ☑		igin? (Specify Yes or N n, Puerto Rican, etc.) :	Bla	ice - Americ ack, White, ify: WHI	etc.
5-0	n 72 hours "naturel",	leted	15. Decedent's (Specify only highest of	Education grade completed)	16	a. Decedent's Usual ( (Give kind of work life. DO NOT use	Occupation done during mos	st of working	16b. Kind of E		dustry
2121	i filed within 72 hour I Hygiene. other then "naturel	Completed	Elementary/Secondary (0-12) 8TH	College (1-4or 5-	+)	MACHINE OF			COMMERI	.CAL C	JUKKEGATED
Maryland 21215-0036	0 to 0	To Be C	17. Father's Name (First, Middle, La EARL FRANCES BRA					er's Name (First, Middle RY CREED	le, Maiden Suma	me)	
Aary	and and ls m		19a. Informant's Name/Relationship					er or Rural Route Num ET, BALTIMO			
	s 1 and 3 of Health item 27		MARY KOEHLER/MOT	HEK		of Disposition (Name ery, crematory or other		Date Date	20c. Location		
E O	Pages nent of int: If it		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from State cify)		iery, crematory or othe IORE/WASHII	1	5/11/04	LAUREL,		
Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or of		21. Signature of Funeral Service Lic	ensee		22. Name and 6224 EAS		ity CHARLES /E., BALTIM			
6	Physician /Medical Examiner		23a. Flart . Enter the disease, or construct, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Narcotic  Due to (or as a	e. Intox a consequence	ication e of):	of dying, such as	s cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a							
P.O. Box 6	that the death certific ed by the attending p detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal dea	th 3 □Ectopic preg 5 □ Other (spec				ate of delive	ery Day Year
	luires that n signed b		Part II. Other significant conditions	s contributing to death bu	it not resulting	in the underlying cau	se given in Part	•		ntribute to th 3 ☐ Prob	he cause of death? bably 42/Unknown
Vital Records,		Completed						24a. Wa aut per 1 Yes	formed?	death?	opsy findings available impletion of cause of
Vita	ysicien: The is certificate hidirector, page	Be	25. Was case referred to medical examiner? 1 XYes 2 □ No	Hospital:	-1 0 TER	Outpatient 3□ DOA		e of Death <i>(Check only</i> ursing Home 5 Res		Shar (Canai	At Scene
Division of	ding Ph After th funeral	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	3/0/04	y 28b		: Injury at Work? 1 Yes 2 w	28d. Describe	how injury occu		y At beene
Divis	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the f	Certification:	3 Suicide 6 Could no determin	28e. Place of Inju- building, etc Found a		farm, street, factory, o	office		(Street and Non own, State) 81 more, Md		OldhamSt.
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☑ Medical Ex	Physician: To the best of caminer: On the basis of and manner sta	examination a	ge, death occurred at and/or investigation, in	the time, date a my opinion, de	nd place, and due to the ath occurred at the time	e cause(s) and m e, date and place	nanner as s , and due to	tated. o the cause(s)
	To ti withi To ti comp	Ž	29b. Signature and title of certifier	uniz-to	Slan		.C.M.E.		29d. Date sign. May 6,		Day, Year)
			30. Mame and address of person with	TONICA-t	DIA	(Type, Print)  Aubl 1 Pen	n Street	t, Baltimor	e, Mary	land 2	21201
	St	ate	31. Date filed (Month, Day, Year)	3. Registra	ar's Signature						

State Registrar

MAY 1 3 2004

38. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** May 0230 A Wade Leroy Cincibus 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 358 Leeanne Road Rosedale Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) 05/31/1928 Birthplece (State or Foreign Country) **Funeral** 1 € M 2 □ F 75 Yrs 217 24 9487 Director Maryland Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itsm 27 is marked other than "natural", or Items 23a or 28a-f shot other traumatic event, the Medical Examinar must be untilled at Baltimore Essex 1 Yes 2 XNo Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 358 Leeanne Road 21221 **USA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Korean 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Highway Administ. Highway Design and Mental Hygi-Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be find Mental H Anton Cincibus Mary Harris ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If itsm 27 Is m any Injury or other traun once. WIFE 358 Leeanne Road Essex Maryland 21221 Theresa Audrey Cincibus 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5-13-2004 Catonsville MD Metro Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Runeral Service Licenses 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup> Cvach/ROsedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 400 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Artoniosel motic (andiovascular Disease **Physician** 10 years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy certificate 1 ☐ Yes 274 No spitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 sesidence 6 Other (Specify) ၉ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funerel E comuletely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 2 29c. License number Tot 29d. Date signed (Month, Day, Year) D18667 Name and address of person who completed cruse of death (Item 23a) (Type, Print) Hiller Luthenville Maryland 21093 31. Date filed Month, Day, Year) 32. Registrar's Signature State 3 2004 MAY 1 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygien 2001 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May  $1^{\text{Day}}$ 2004 **Physician** Minnie Ethe1 Dorsett 5:40am M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard County 12105 Frederick Road Marriottsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct. | 29 Birthplace (State or Foreign Country)
 NC 5. Social Security Number 7 Age (In vrs. last birthday) Year) 905 **Funeral** 1 ☐ M 2 🕅 F 579-34-0577 98 98 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r than "natural", or Itams 23e or 28e-f shot the Modical Examinar must be notified at Md Howard Marriottsville 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12105 Old Frederick Rd. 21104 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give <sup>2</sup> Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene important: If itam 27 is marked other than "natural; or Itan any injury or other traumatic event, the Medical Exeminations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) domestic Elementary/Secondary (0-12) College (1-4or 5+) homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlie Wilson Virginia Harrison P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1275 Guilford Rd. Eldersburg, Md 21784 Wanda Souder (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Srv. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/04 Sykesville, MD All County Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee <sup>2</sup>HATGHI ACHURERATI Sykesville, MD HOME & CHAPEL, PA (B 21784 (410)-795-1400 PA (Box 195) 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No the detached 9 Unknown 9 ☐ Unknown þ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ρ peq 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has certificate 1 Yes 2 No of Vital the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? unera 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: within 24 hours after death. To the Funeral Director: After Injury Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation in by the 1 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, 87 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #5 per G.Sparks G834.8/12/04 tas

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** DeGraffinried Jrmn. 10:02 Clifton 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGAN HOSPITAL HEART um berland DACRED 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 5.214-68-4469 Months 1**⊠**M 2□F Days Hours Min. 46 216-68-4469 Usual Residence of Decedent 14 MD 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County 1 ☐ Yes 2♥ No Director Cumberland MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 U.S.A. 13800 McMillian Highway by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Never Married 2 Married 1 ☐ Yes Z XNo 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Year or Dates: Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator 12th grade Machine Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Clifton DeGraffinried Marion Springfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother Marion DeGraffinried 2924 Forest Glen Road, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 5/15/04 Baltimore, Md 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi ic or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final age Euch SX disease or condition resulting in death) Due to (or as a conseque of): euce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Ecos that initiated events resulting in death) Last Due to ( as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 10m10 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 2 2 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner the attending physician and hed for use as the burial-transit P.O. Box 68760 Division of Vital Records, funeral director, To the Hospitel or Attend within 24 hours after death To the Funeral Director: filled in by

**Funeral** 

Director

28a-f show

ō items 23a

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"natural"

al Hygiene.

permit. Pages 1 and 2 should be filit Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

Physician

/Medical

traumatic event, the Medical Examiner nust be notified at

with the Maryland

Baltimore, Maryland 21215-0036

B

Registrar

DHMH 17 Rev 1/2001

Uriel Verandia 902 Seton Drive Cumberland, rud 31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2004

boaked

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00 8377

29d. Date signed (Month, Day, Year)

4,2004

Irvin	Dubin		m#23a,27,28a-f,PRME For Amend Items 10 1 - State Registrar			do57e3/		Health and M			2004	15343			
04-312			Decedent's Name (First, Middle, La	ist)					2. Date of D	eath		3. Time of Death			
AKG	Physicia /Medic		IRVIN				DUBIN		Month May 8,	200		12:50 P <sup>M</sup>			
	Examin		4a. Facility Name (If not institution, given	re street and number)			4b. City, Town, o	or Location of Death	1	40	c. County of Dea	th			
			3211 Clarks Lan				Baltimo		1000		N/A				
20	Funeral		5. Social Security Number 6. S	Sex 7. Ag 1⊈M 2□F	e (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D 02/25/1	ay, Year	9. Bin	hplace (State or Foreign ountry)			
3	Director		212-20-7316 Usual Residence of Decedent	٨	/ 6	)			02/23/1	.920		MD			
	yland		10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits				
	a-fal	Director	MD N/A		321	1 CLAR	KS LANE	#315 Balt	imore			1 X Yes 2 No			
	or 28	Oire	10e. Street and Number				10f. Zip Code				itizen of What Co	ountry?			
	ath w	rall	3211 CLARKS LANE			0 10	21215	Uli			U.S.A.				
98	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f ahow raumatic event. I'm Medical Evant at most be ricilized at	by Funeral	11. Marital Status <b>Divorced</b> 1 Never Married Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		1	Vas Decedent of I f Yes, specify Cub I ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or N p Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: WH				
Ş	2 hou		15. Decedent's E	ducation		16a. Dece	lent's Usual Occu	pation	leis a	16b. l	Kind of Business	Industry			
21215-0036	swithin 72 hour jiene. r than *natural the Medical El	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or !	5+)	life.	or work done  OO NOT use retire	during most of wor. ad)	KING						
21	ed wi	Con		4		SALES		40.14.15.1.11.	(PT)		MERICAL	GLASS			
Maryland	be filed htal Hyg ed other event.	Ве	17. Father's Name (First, Middle, Las	")		DUDT	N1	18. Mother's Nan	ne (First, Milaaie	e, Maide	п Ѕитате)	CINCDEDO			
3	d Mer narke natic	Lo	ISRAEL  19a. Informant's Name/Relationship	(Type Print)		DUB I		SOPHIE t and Number or Ru	ral Boute Numl	oer City	or Town State	GINSBERG			
Ma	D =			SON			WESTDALE		IMONIUM			<i></i>			
	s 1 and 2 should Health and Mer Item 27 is marke other traumatic		20a. Method of Disposition		20b. i	Place of Dispo	sition (Name of natory or other pla	1	Date		ocation - City or	Town, State			
Baltimore,	permit. Pages 1 and Department of Heall important: If item 2 any injury or other once.		X☐ Burial 2 ☐ Cremation 3 ( `4 ☐ Donation 5 ☐ Other (Special			-	NS CEMET		2/2004	OW:	INGS MIL	LS. MD			
量	mit. F partm portar injur		21. Signature Funeral Service Lice		1		. Name and Addre	-		-	& BROS.				
m	P P P P P P P P P P P P P P P P P P P	l 15	Quitar W	Leuner	a	8	900 REIS	TERSTOWN	RD PIKE	SVIL	LE MD 2	1208			
•	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	ne. <b>Ig anc</b>	l alcoho	er the mode of dyi		or respiratory	arrest,		Approximate Interval Between Onset and Death			
3	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consec	uence of):									
68760,	aath certificate be executed attending physician and for use as the burial-transit	dical Examiner	that initiated events resulting in death) Last	cDue to (or as	a consec	(uence of):									
P.O. Box 6	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	aldeath 3[	Ectopic pregnand Other (specify)	;y			23d. Date of de Month	ivery Day Year			
	that ned by deta	by Ph	Part II. Other significant conditions	contributing to death b	ut not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?			
rds	quires in sign								1 🗆	Yes 2	No 3 □ P	robably 4 Unknown			
Division of Vital Records,	iician: The law re certificate has bec rector, page 2 sho	Completed							24a. Was auto perf 1 🗌 Yes		death?	utopsy findings available completion of cause of			
ita	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	Hasekel				26. Place of Dea							
) (	physic this c	1º	1 X Yes 2 □ No	Hospital: 1 Inpati		ER/Outpatier	I 3 DOA		ome 5 ☐ Res			cityAt scene			
on c	ding I h. After funer	Certification:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigate	28a. Date of Inju (Month Date on <b>found</b> 5/8	(04)	Injury Unkn	Wo	ork? ∐Yes 2. TXNo				and alcohol			
isi	Attendest deatl	lica	3 Suicide 6 □ Could not	be 28e. Place of In	jury - At h	ome, farm, sti	eet, factory, office		28f Location	(Street a	nd Number or Ri	ural Route Number			
Οįν	after after Dire	erti	4 Homicide	home houlding, e	ic."(Speci	fy)			3211 Cla	rks I	aned, Bal	timore, MD			
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C		hysician: To the best miner: On the basis of and manner st	f examina				, and due to the	cause(	s) and manner as	s stated.			
	To the within To the comp	Me	29b. Signature and atte of certifier	1 ~			29c. Licen	se number		29d. D	ate signed (Mont	h, Day, Year)			
			1 Co	Kemp			0.C	.M.E.			May 9,	2004			
			30. Name and address of person who	of impleted cause of	)			n Street,	Baltim	ore,	Maryla	nd 21201			
	Sta	ațe	31. Date filed (Month, Day, Year)	82. Regist	rar's Sign	ature.	low VI								

State of Maryland / Department of Health and Mental Hygiene [] [] []

For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Herbert L. Elliott 05/11/2004 11:00 5 m /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1423 East Clement Street Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours XXM 2 F 214-01-0720 89 Director December 17, 1914 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County id other than "natural", or Iteme 23e or 28e-f ehow event, the Medical Exertance must be notified at MD N/A Baltimore City 1 Xes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1423 East Clement Street 21230 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**XX**No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or ite, any injury or other traumatic event, the Medical Example once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ White 3 ₩idowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Shipping Longshoremen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles A. Elliott Marie G. Nun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holden J. Hodges, Jr. /Grandchild 7613 Beaver Road, Glen Burnie MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. May 14, 2004 Baltimore Maryland 21. Signature of Juneral Service Lieux Victor P. Doda, Jr22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. proximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CINOMA Physician A /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, localing to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown cate has been signed; page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 HO Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To After this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 DU5103 B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUNGE UF 10 1-0 8t a 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 3-2004

Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1800PM 2004 Dr. Theodore E. Evans /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Stella Maris at Mercy 8. Date of Birth (Month, Day, Yeer) Mar. 17,1929 If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 15 Yrs. Maryland 215-28-0393 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "netural", or Items 23a or 28a-1 show ury or other traumatic event, I'm Medical Examinating intuit be notified at 1 ☐ Yes 2 🙀 No Director Nottingham Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4012 Kahlston Road 21236 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 □ No If Yès, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self-Employed Elementary/Secondary (0-12) College (1-4or 5+) Physician Physician 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Henry Edward Evans Catherine Huebler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Midcrest Ct., Towson, MD 21286 Mr. Todd Evans (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If sny injury or once. 5/11/2004 Parkville, Maryland Parkwood Mausoleum \* 4 □ Donation 5 ▼ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes Buín a. Weller 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) prostute **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, 1.3 y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Cther (specify) P.O. – 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cete hes to autopsy performed certificete 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 32 No Medical Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After Natural 5 Pending within 24 hours after uc...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 040854 2004

Registrar

State

30. Name and address of person who co

31. Date filed (Month, Day, Year) MAY 1 3 2004

1211

Paul Pl

Baltimore

21203

repleted cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

sebern

		1	For State of Maryland / Dep State Registrar  State of Maryland / Dep	artment of Health and N ertificate of Death	Mental Hygier		15346		
	Physicia	an	1. Decedent's Name (First, Middle, Last) William B. Fitzpatrick			Day Year 11 2004	3. Time of Death  1:20P M		
42	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death			
			8912 Mavis Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Baltimore  If Under 1 Year If Under 24 Hrs.	8. Date of Birth				
-	Funeral Director		217-05-9999 XX <sup>M 2□ F</sup> 85 Yrs.	Months Days Hours Min.	(Month, Day, Yea	918 Count	₿		
	and	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation		10	d. Inside City Limits		
	Mary if aho	tor	MD Baltimore Balt	imore			1 ☐ Yes 2 ☐ No		
	h the r 288	lrec	10e. Street and Number	10f. Zip Code			ry?		
	23a c	Ta D	8912 Mavis Ave.	21236		USA	1.00		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow important: if Item 27 is marked other than "natural" and any injury or other traumatic avent, I've Medical Exam her must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Named Forces?  1 Never Married 2 Named Forces?  1 Never Married 2 Named Forces?  1 Never Married 2 Named Forces?  1 Never Married 2 Named Forces?	. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, White, e	etc.		
Maryland 21215-0036	72 hou natura	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king 16b.	Kind of Business/Ind	ustry		
12	2 should be filed within and Mental Hygiene. is marked other than sumatic avent, the M.	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	er Chief Petty Off	icer	U.S. Navy			
<u>ğ</u>	e filed Hygi other	e C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid				
ylar	should be filed withind Mental Hygiene.  I marked other than umatic avent, I to M	To Be	Bernard F. Fitzpatrick		Peddicord				
Zar	12 sho h and 7 is m traum		, , , , , , , , , , , , , , , , , , , ,	ling Address (Street and Number or Ru					
	Healt Healt tem 2		Colleen Iwanowski/Daughter 270.  20a. Method of Disposition 20b. Place of Disposition	operation (Name of ematory or other place)	Date 20c.	Location - City or To	wn, State		
E O	Pages nent of int: if I		1 □ Burial 2 □ Cremation 3 □ Hemoval from State  1 □ Donation 5 □ Other (Specify)  Bayview	Crematory May	15, 2004	Baltimore,	Md.		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sci 19705 Belair Rd., Ba	himunek Fu	neral Home	s		
	E 45		23a. Path. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	/ ARIERT	Diser	56	Olizer and Death		
B	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	Airus		Baltimore  9. Birthplace (State or Foreign Country)  10d. Inside City Limits  1			
	Rose -	er	if any leading to immediate Due to (or as a consequence of):	6,43,4		en Sumame)  y or Town, State, Zip Code)  M			
Con	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
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s, P	requires that the de seen signed by the hould be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	. /				
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/ita	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?	Othor	th (Check only one)				
of	Phys this ral dii	. To	1  Yes 2 No Hospital: 1  Inpatient 2  □ ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how in	6 □Other (Specify njury occurred	<u>)                                    </u>		
lon	Attending I r death. ector: After by the funer	ation	1 Natural 5 □ Pending (Month, Day Year) Injun 2 □ Accident investigation	of 28c. Injury at Work?  M 1 Tyes 2 No		•			
Division	- 0	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, building, etc. (Specify)	street, factory, office	28l. Location (Street City or Town, St		Route Number,		
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)		
	To the Within To the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, I	Day, Year)		
) i	11		30. Name and address of person who opmpleted gause of death (Item 23a) (Typ	D 305 10		T1 14, 0	2000		
	011	nto.	BERNMO H- KAVITZ M.D. 563  31. Date filed (Month, Day, Year)  32. Registrar's Signature	eg Lunt Corner	KOAD WITH	16 HATI M	1) 21/6/		
	St Regist	ate rar	MAY 1 2 2006 be were &	and the					

ORIGINAL

William.

			For State Registrar	State of Maryla		artment of H rtificate of L			iene 004	15347
	Physicia		Decedent's Name (First, Middle, Last)     Movemand C. C.	'au I d				2. Date of Deat Month MAY	Dav Year	3. Time of Death
	/Medic	al	Morris G  4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	MAI	4c. County of Dea	1:15p M
	Examin	er	1413 Tarragon Co				camp		Harford	
	Funeral Director		119-07-3061	M 2□F 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month., Day, AUG 4,	1918 Nev	thplace (State or Foreign buntry) 7 York
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Maryl fied a	ţō	Maryland Harford		Belcamp					1 ☐ Yes 2 📉 No
	h the or 28e	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	23a c	Funeral Director	1413 Tarragon Cour			21017			ISA	
	er deg	une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent Ever in Armed Forces?</li> <li>1 ✓ Yes 2 ☐ No</li> </ol>	n U.S. 13.	Was Decedent of Hi If Yes, specify Cubai	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
39	72 hours after death with the Maryland natural; or Itams 23a or 28e-f show Jisal Ezama act must be Ladified at	þ	3 ♥ Widowed 4 □ Divorced	MAX Chia	1943 <b>-</b> 1946	1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
2-0	72 hor	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa	uring most of worki	na	16b. Kind of Business	Industry
12	within ene. then "	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,			Credit Uni	on
Maryland 21215-0036	e filed within al Hygiene. I othar than " vant, Ing Mg	O e	17. Father's Name (First, Middle, Last)		Manag	ger	18. Mother's Name	(First, Middle, M		.011
an	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene and the state of the stand stands or 28e-1 show item 27 is marked other than "natural", or Itams 23a or 28e-1 show other treumatic evant, the Medical Exerting Institute Indifferent orbants and the stands of the	To Be	Samuel Gould				Reba			UNK.
ary	2 should be and Mental is marked reumatic ev		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street a	nd Number or Rura	i Route Number	City or Town, State,	Zip Code)
	s 1 and 2 of Health a itam 27 is othar tree		Shirley J. Bouche			3 Tarra or		Belcan		
ore	Pages 1 nent of H int: If ital iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State		osition (Name of matory or other place	15 10		20c. Location - City or	
Baltimore,	it. Pa rtmen rtant: njury		* 4 □ Donation * 5 □ Other (Specify)  21. Signature of Funeral Service License			ematory Ir	10.		Baltimore	e, MD
Ba	permit. Pages Department of I Important: If it any injury or o once.		Thomas Gregor	ige -	7	R. Name and Addres Cremation 299 Freder	Society ( ick Road	of MD, I Balti	nc. more, MD	21228
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the decause on each line.	eath. Do not en	ter the mode of dying	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Fnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	chronic		regice	pas-	money.	y Dise	x 54ea
ı	Examiner			Due to (or as a con	sequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):  Due to (or as a consequence of):						
	ocuted nd transi	Examiner	that initiated events							
8760,	certificate be executed nding physician and use as the burial-transit	al Ex	resulting in death) Last	Due to (or as a con	sequence of):					
687	ficate physics the	edical								
. Box	atter tor u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	ivery Day Year
P.0	that the de led by the a	Phys	9 ☐ Unknown  Part II. Other significant conditions con		rogulting is the	underhing gaves ave	n in Port I	23e Did tob	pacco use contribute to	the cause of death?
ds,	8 50	d by	Falt II. Other significant conditions con	and the death out not	resulting in the c	indenying cause give	mant att.	1 <b>Y</b>		obabiy 4 🗆 Unknown
Vital Records,	3 71 %	ompleted						24a. Wasa		itopsy findings available
Re	: The la cate has page 2	mo						autops perform	ned?   death?	completion of cause of
ta	3 -							1 ☐ Yes 2		4 L 140
Name of Street	cian: ertific	Be C	25. Was case referred to medical examiner?				26. Place of Death			20110
of V	physician this certifi al director	To Be	examiner? 1 ☐ Yes 2 💢 No		2 ER/Outpatie		or: 4 ☐ Nursing Ho	(Check only on	e) nce 6 Other (Spe	
o	ing Physician Atter this certifi uneral director	To Be	examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending	ospital: 1  ☐ Inpatient 28a. Date of Injury (Month, Day Yea	1	of 28c. Injury Work	A Nursing Horat	(Check only on	9)	
o	ttanding Physician Jeath. tor: Atler this certifi the funeral director	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide  6 Could not be	28a. Date of Injury (Month, Day Yea.	28b. Time of Injury	of 28c. Injury Work	4 □ Nursing Ho at ? (es 2 □ No	(Check only only only only only only only only	y a) nce 6 □Other (Spewinjury occurred	cify)
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o	To the Hospitel or Attanding Physician within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director.	edical Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	28a. Date of Injury (Month, Day Yea.  28e. Place of Injury - A building, etc. (Sp. sician: To the best of my ter: On the basis of examples.)	28b. Time of Injury  At home, farm, st ecify)	of 28c. Injury Work M 1 \( \text{N} \)  reet, factory, office the occurred at the time treetigation, in my open to the control of the time treetigation.	at .?  es 2 No	Check only on.  1 (Check only on.  1 (Check only on.  28 (Reside 28d). Describe house to the care of the time, do not consider the time, do not consider the time, do not consider the time.	nce 6  Other (Spe w injury occurred reet and Number or Re , State)	ural Route Number, stated. to the cause(s) h, Day, Year)
of	or Attanding Physician titer death. Director: Atter this certifi in by the funeral director	edical Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who co	28a. Date of Injury (Month, Day Yea  28e. Place of Injury - A building, etc. (Sp  sician: To the best of my her: On the basis of exan and manner stated.	28b. Time of Injury  At home, farm, st ecify)  knowledge, death ination and/or in	get actory, office  28c. Injury Work 1 1 1  reet, factory, office  th occurred at the tim restigation, in my op  29c. License	at	Check only on.  1 (Check only on.  1 (Check only on.  1 (Check only on.  28f. Reside 28d. Describe ho 28f. Location (St.  City or Town  28f. L	nce 6 □Other (Spe w injury occurred  reet and Number or Ri , State)  suse(s) and manner as atte and place, and due	ural Route Number, stated. to the cause(s) h, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Day **Physician** 9, **GOLDMAN** 2004 12:20 A M GERALD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FUTURE CARE CHERRYWOOD REISTERSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

JUNE 29, 1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1₩ M 2□F Yrs. 220-74-5941 MD Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No **Funeral Director** BALTIMORE REISTERSTOWN 10e. Street and Number 10g. Citizen of What Country? 12020 REISTERSTOWN ROAD 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. other than NONE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth **GOLDMAN** LEAH WEINBERG LOUIS traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HIGHSTEPPER COURT #303 - BALTIMORE, MD 21208 ELAINE SALGANIK / SISTER Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Itel
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State ANSHE EMUNAH (AITZ CHAIM) 5/11/04 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failyre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascala Cereho-1 20715 Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day ò 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has al director, page 2: autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No P After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Roch J. Mon. in & 3288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dive Reinfranton Bullians Co L. Moss 1/7 2/13 6 31. Date filed (Month, Day, 2004 62. Registrar's Signature State Registrar

			For Amend Items 25 Registrar  1. Decedent's Name (First, Middle, L		per Dr. Ce	nificate of	Death	2. Date of Death	1	04	3. Time o	349 of Death
	Physicia	an	Frances C. Gree					April 13	3, <sup>Day</sup> 2004	Year	5:38	АМ м
0	/Medic Examin	- 2	4a. Facility Name (If not institution, go Suburban Hos			4b. City, Town, Bethes	or Location of Death da		4c. County Montg			
v	Funeral Director		5. Social Security Number 6. 258–28–3731		yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Mar 27,	Date of Birth (State or F. Country) ar 27, 1917 Georgia			or Foreign
-	faryland f ehow	or	Usual Residence of Decedent           10a. State         10b. County           MD         Montgo		c. City, Town or Lo Beth						0d. Inside 0	City Limits
	death with the Maryland ms 23s or 28s-f show rmast be trafffed at	Director	10e. Street and Number 5215 W. Cedar La	-		10f. Zip Code	20814	10	og. Citizen of W	/hat Cour	try?	
0 9	after death or Items 23	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1Yes 2 2 No If Yes, Give	r in U.S. 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)				
7 4 3. S. S. S. S. S. S. S. S. S. S. S. S. S. S	72 hours "netural", edical Exe	Completed by	3 X Widowed 4 □ Divorced  15. Decedent's (Specify only highest g	Year or Dates:  Education rade completed)	(Give	dent's Usual Occi	upation	g most of working			Business/Industry	
500	l withir iene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 4			teacher		edu	cati	on	
Maryland 2	ild be filed lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Las Frederick	•		18. Mother's Name (First, Middle, Maiden Sumarne)  Ruth Maddox						
Mary	d 2 shouth and M		19a. Informant's Name/Relationship Robert Green/son			•	et and Number or Rui	ral Route Number, Washing t				
//3/04 Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinat must be indiffied at once.		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec	☐Removal from State	20b. Place of Disposemetery, cre				20c. Location -			
4/73 Balti	permit. Departrimports any inju		21. Sin atur of Euneral Service Lice Konald S.	Wade Mirec	tor S	2. Name and Add tate Ana altimore	ress of Facility tomy Board , MD 2120	1 <sub>1</sub> 655 W.	Baltimo	re S	treet	
	Physician		23a. Patt1. Enter the disease, or co- shqck, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused the yone cause on each line.							Approxima Interval Be Onset and	ate etween
30	/Medical Examiner	10	resulting in death)  Sequentially list conditions,	Due to (or as a co	Me	odala	lead ?	regare	lein	)		
0530	be executed lician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co	0							
94.00		dicai		d								
CC Box 6	The law requires that the death certificate are been signed by the attending physoage 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnan ⊒ Other (specify)			23d. Dat Mor	e of delive	Day	Year
ZAN	quires that the signed by ald be detact	ed by Ph	Part II. Other significant conditions	contributing to death but no	\_	ınderiying cause ç	given in Part I.		pacco use contr		ably 4 □	
SIREGN HILA	icien: The law requir certificate has been s rector, page 2 should	Completed						24a. Was ar autops perform 1 Yes 2	y p	Vere auto prior to co leath?	psy findings npletion of 2 \( \subseteq \text{No} \)	available cause of
/ita	cien: sertifica ector,	Be	25. Was case referred to medical examiner?	Hospital:			har	th (Check only one				
1/2 of 1	ding Physi n. After this c	. To	1 ☐ Yes 2 🛣 No  27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	nt 3L DOA		ome 5 Reside 28d. Describe ho			r)	
(s)	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	12 Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be One Place of Injury		M 1	☐Yes 2☐No	28f. Location (Str	reet and Numb	er or Rura	I Route Nu	mber.
Div	otel or Attencers after death	Certif	4 Homicide determine	building, etc. (5	Specify)			City or Town	, State)			
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical		Physician: To the best of m aminer: On the basis of ex- and manner stated	amination and/or in			rred at the time, da	ate and place, a	and due to	the cause	(s)
•	To t To t	Σ	29b. Signature and trik of certifier	1111871	1100	0		7 -	May 12,		Day, Year)	
		- 1	30. poe and address of pe on what	complete cause of death	h (Item 23a) (T e	Vhur.	DAN 1	OSPI	tA1			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32/Registrar's	Signature	Sports		1				
D	HMH 17 Rev 1/2	2001	MILL T A TOOL	ŕ	*							

ORIGINAL

Ronald Hunt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02766 Unpend Item#23a,27,PER ME C8326/2/00 Department of Health and Mental Hygiene 1 RPD 15350 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Ronald Hunt. April 0325\_P<sup>M</sup> 22, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Belair Harford 5. Social Security Number 243–19–7300 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 F 30 Months Days Hours Director 26, 1973 NC Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "neturel", or Items 23a or 28e-f show the Medical Examinar must be notified at MD Harford Aberdeen 1 Yes 2 XX Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11 Osborne Rd 21001 USA death Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yes Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Restaurant 11 0 Cook marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill thent of Health and Mental Hitant: If Itan 27 Is marked oth Be Randa11 Leadkey ٩ Judy Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyrone Hunt / Brother 259 Silo Drive Rowland 28360 NC Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) = 5 Department Important: If any injury or Lumbee Memorial Gardens April 28, 2004 Lumberton, 21. Signature of Funeral Service Licensee Thomas P. Zizos Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore Md. 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No Yes 2 No Yes director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYYes 2 ☐ No Certification: To 1 Inpatient 2√CXER/Outpatient 3 □ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 23, 2004

3

State Registrar

31. Date filed (Month, Day, Year) MAY 1 3 2004

e and address of person

who completed cause of death

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 0 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 5 Headley Monica Α. 2004 9 0032 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Arundel Hospital Glen Burnie Anne Arundel Co. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛣 F Yrs. 578-06-4556 Director 8-26-35 Jamaica Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location ortant: If itam 27 is marked othar then "naturel", or Itams 23a or 28a-f show injury or other traumatic avant, Ite Madical Examinat he must be madical 10d. Inside City Limits NJ Burlington Westampton Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 Rolling Hills 08060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. If itam 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Nurses Assistant Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Campbell Ena Mae Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Benjamin 1419 Cowsill Ave., Severn, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Denbigh Cem. 5-22-04 \* 4 ☐ Donation 5 ☐ Other (Specify) Clarendon, Jamaica 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 Wane March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician CARDIO MYOPATHU EVEN /Medical Due to (or as a consequence of): EANS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Day Year 5 Other (specify) ed by the detached 9 🗌 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? HYPERTEN SION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 2 1 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funarel Director: After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 DER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 [Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Con 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORMAN

SMITH, 2905 MITAL 2905 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Year Patricia Holland 8:40 P M MAY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITIZENS NURSING HOME FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 066-24-3126 1 M 2 XF LANCASTER, NY Yrs. 09/11/1930 73 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow traumatic event, the Medical Exacting must be notified at 1 ☐ Yes 2√√ No Directo MARYLAND FREDERICK DETOUR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 11053 HAUGHS CHRUCH ROAD 21757 LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 Yes 20 No Specify Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE CAFFTERIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDNA M. NOLL ALLEN ERNEST BULL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11053 HAUGHS CHURCH ROAD, DETOUR, MARYLAND 21757 JANEL C. HOLLAND-LINN (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai XXI Cremation 3 ☐ Removal from State BAYVIEW/CREMATORY 5/12/2004 BALTIMORE, MARYLAND \* 4 □Donatjon 5 □Other (Specify) e if Funeral Service Licens 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HICHWAY S., GLEN BURNIE, MD 21061 NK #M01148 23a. Part1 Enter the disease shock or heart failure. nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Circholis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> 3 Probably 4 □Unknown 1 Tyes 2 410 Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has 1 Yes or Attending Physician; funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 📉 🗸 🗸 🗸 🗸 1 🖂 1 Inpatient 2 ER/Outpatient 3 DOA Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 1. Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of costifier D0031058 5-11-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene F. Ashe, MD 10200 Coppermine Rd, PO Box 6 Woodsboro, MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William T. Hobbs 1- For Unpend Item #23a,27,28a-f per me (83) 5/14/04 tas Certificate of Death

Reg. No. UNK 04-119 04-2390 AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1 hamas HigM April 2004 /Medical 10:10 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4700 block of Pulaski Highway Belcamp
If Under 1 Year | If Under 24 Hrs. Harford 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Days 414-26-8543 Yrs. Director ENA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Harton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 or Items 23a 15H Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∠Yes 2 ☐ No IYes, Give Year or Dates: //4/6-/967 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK 3 Widowed 4 Divorced Specify: "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) if Health and Mental Hygiene. College (1-4or 5+) COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) WiFe DELLA HODDS CONOWINGS Department of H Important: If Itei any injury or oth once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Greenmount 21. Signature of Funeral Service License xure Ww 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Multiple Injuries resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 MUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼ Yes 2 □ No autopsy performed? this certificate 1X Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) At SCENE XXYes 2 □ No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After □Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2X Accident 4/7/2004 the 10:00 within 24 hours after death To the Funeral Director: A Subject Struck By Train 3 Suicide 6 Could not be 28f. Location (Street and Number of Rural Raute Mumber, City or Town, State) 4700 Block of Pulaski 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Train Tracks Hwy., Belcamp, Md the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of conflier 29c. License number 29d. Date signed (Month, Day, Year) April 8, 2004 O.C.M.E. 30. Name and address of per in who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201 State Registrar's Signature 1 3 2004 Registrar DHMH 17 Rev 1/200

**ORIGINAL** 

				1- For State of Maryla	nd / Depa	artment of Health and rtificate of Death		iene 2 0 0 4	15354
		Physici		1. Decedent's Name (First, Middle, Last)  ARTHUR ALBERT		JSON	2. Date of Deat		3. Time of Death
	1	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	ith	4c. County of Death	17710
			\$ .W	Upper Chesapeake Medical Cente		Bel Air	S O Date of Dist	Harford	
		Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs	s. last birthday) Yrs.	Months Days Hours Mir			place (State or Foreign plry) W Jersev
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		th with	al D	1616 Watervale Road		21047		United Sta	ites
	980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: It item 27 is marked other than "natural", or iteme 23a or 28e-t ahow any injury or other traumatic event. It a Medical Example in unit by notified at ance.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
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7	altimore, Maryland	d 2 sh th and th and 17 is m traum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or F			Code)
5/10/04	ē,	s 1 an f Heal item 2 other			Place of Dispo	Watervale Road, sition (Name of natory or other place)		MG. ZIU47 20c. Location - City or To	own, State
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3	i.	/Medical Examiner		resulting in death)  Due to (or as a conse	equence of):				
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(	rds, P	w requires that the der been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not re	isulting in the ur	nderlying cause given in Part I.	23e. Did tob	acco use contribute to the s 2 □ No 3 □ Prob	
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anson	Division	al or Atter s after dea I Director d in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre ufy)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura State)	l Route Number,
He		To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my kr (Check only one) Certifying Physician: To the best of my kr (Check only one)	nowledge, death	n occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the caurred at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
		Mithi To t	Σ	29b. Signature and fille of certifier \\ \\ \\ \\ \\ \\ \\ \\\ \\ \\ \\ \\ \	BYRNE	29c. License number  H -59432	5	d. Date signed (Month,	Dey, Year)
		10		30. Name and address of person who completed cause of death (lite	m 23a) (Type, I	Print) CHESAPEAK	E - AFI	NIO MA	21014
	4	Sta Registr		31. Date filed (Month, Day Year) 32. Registrar's Sign	nature	frank 1		77	

State of Maryland / Department of Health and Mental Hygiene 0 1 15355 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 12. Year **Physician** 2004 12:50a.M BETTY MAXINE JONES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7914 33rd Street Rosedale Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Social Security Number **Funeral** Days 1 □ M 20XF 235-30-5234 79 WEST VIRGINIA Director 7-3-1924 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 ie marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No MD BALTIMORE ROSEDALE **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 7914 33RD STREET 10f. Zip Code 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE À 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 le marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLER WESTERN ELECTRIC 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle, Last) Be **JAMES** YANERO LAURA (GLOVER) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROGER M. JONES (HUSBAND) 7914 33RD STREET ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of Himportant: If ite any injury or of once. Burial 2 Cremation 3 Removal from State DULANEY VALLEY MEM. 5-15-2004 4 Donation 5 Other (Specify) TIMONIUM, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Cvach/Rosedale Funeral
1211 Chesaco Avenue Rosedale Maryland Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that caused the death. shock, or heart failure. List only one cause on each liv Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed and the attending physician a ned for use as the buriat-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ď 99 3 Probably 4 □Unknown ted Comple 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury - 🗆 ivatoral 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide + Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 20 eted cause of death (Item 23a) (Type, Print) Pogistrar's Algriature State Registra

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 6:50P MAY ANNA K 20HN50N S /Medical 2004 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia MD Howard If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplece (State or Foreign Country) **Funeral** 89 Months 1 □ M 252 F 191-03-0331 Aug. 22, 1914 Director PΆ Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location r than "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Howard Ellicott City 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 North Ridge Road 21043 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married □Yes 2√No Baltimore, Maryland 21215-0036 þ Yes. Give 1 ☐ Yes XXX No Specify Specifiwhite 3√X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 School District Cafeteria Worker marked other 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental H ant: If item 27 is marked of Leon Kasnevich Nellie Warcholak 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann Johnson / Daughter 5969 Mantaparrery Road, Elkridge MD 21075 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of h = 5 1 ☐ Burial 2 ☐ Cremation XX Removal from State Important: If any injury or QDCS. Lawn Haven Cem. May 13, 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) East Franklin Township, PA 21. Signature of Funeral Se Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** RENAZ ACUTE DAY resulting in death) /Medical Due to (or as a consequence of): Examiner DAYS ROS EPSI Sequentially list conditions, Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed resulting in death) Last burial-t Due to (or as a consequence of) Box 68760. physician Physician/Medical use as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year P.O. I 4☐Pregnant at time of death 5 Other (specify) been signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 3 Probably 4 ∃Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate has autopsy performed? 1 Yes 2 No Vital Attanding Physicien: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Dapatient 2 ER/Outpatient 3 DOA ŏ this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation after death. м 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) pv MAY 1091 2004 DO023120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109BACHRONE NECLIA CUPTA 5 HALENN MALA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® () () |

			For State	State of Ma	iryland / D	epartment of F Certificate of I	leaith and N Death		C	15357
			Registrar  1. Decedent's Name (First, Middle, Las	st)		orimouto or i	Doutin	2. Date of Death		3. Time of Death
	Physicia		Jane D.	Knab	e			May 13	Dey 2004 Year	10:00A M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	r Location of Death	1	4c. County of Death	
			9403 Clocktowe	er Lane		Colum			Howar	
	Funeral		5. Social Security Number 6. S	ex 7. Age ☐ M 2]X] F	(In yrs. last birti	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APR 15,	Year) 9. Birth	place (State or Foreign intry)
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	r 28s	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	th wit	Funeral Director	1207 Brunswick C	ourt			21012		USA	
	ems ems	ıner	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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yla	Ment Ment arked	70	Ralph Diefenbach					Winters		
Jar	2 sh and Is m	ė g	19a. Informant's Name/Relationship ( Timothy A. Knabe	**		Mailing Address (Street . 3810 Cedarbr			•	
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Baltimore, Maryland 21215-0036	nt of 1	. 1	1 ☐ Burial 2 ☒ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specific	Removal from State	ž.	Disposition (Name of v, crematory or other place Crematory,		L4/04	Baltimor	
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	Physicia /Medic		1 Decedent's Nam Stavrou			5								2. Date of May 8	Death , 20	P <b>3</b> 4	Year	3. Time of Death 7:30 a м	
	Examin		4a. Facility Name			eet and nu	m <i>ber)</i>				Town, or Be1	Location Air	of Death		4c. County of Death Harford				
	Funeral Director		5. Social Security 047-32-	9797	6. Sex 1 □ N	1 2 <del>∏</del> F	7. Age (	(In yrs. last birt	hday) Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of (Month, Aug.	Day, Yea	928	9. Birthp Cour Gre	lace (State or Foreign htry) ece	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 15359 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Joseph Kelly Sr. 10 10 2004 8:05 A.M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 322 W. Arden Road Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 9, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1⊠M 2□F 219 18 9030 78 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S. 322 W. Arden Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give WW II Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Mg Elementary/Secondary (0-12) College (1-4or 5+) Inspector Motor Vehicle Adm. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marie Reichert William Leo Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
322 W. Arden Road Baltimore, Maryland 21225 Dolores Kelly / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: ff any injury or once. Glen Haven Mem. Park 5/13/2004 Glen Burnie, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or comp shock, or heart failure. List only lizations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLON CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inimisorials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical the signed by the attending p I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Junknown Completed NEGSTUE 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an has autopsy performe 1 Yes 2 No 1 Yes of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Nesidence 6 | Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ŏ To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 055506 DX

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110

EREN

31. Date filed (Month, Day, Year)

MAY 1 3 2004

3721

32. Registrar's Signature

1	•		1 - For Amend Item 41 Registrar	State of Maper Dr., C831,	<b>arylan</b> ,05/13,	d / Depa /04dhb	artment of	Health and I	Mental Hygid	en2004	15360
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	yland now		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	he Mar Be-fat	Director		ALTIMORE		BALT					1 ☐ Yes 2 ☑ No
	h with t	al Dir	10e. Street and Number  1500 BEDFORD A	VENUE #319			10f. Zip Code	21208	100	g. Citizen of What Co	untry? U.S.A.
336	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Itams 23a or 28e-f ahow avant, the Medical Exam in tribust be invitted at	by Funeral	11. Marital Status 1 □ Never Married 2 ◯ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 □ Yes 2 1 1 1 Yes, Give Year or Dates:		'	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🙀 No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
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Mary	2 shou and N la mar aumat	1	19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Stree	t and Number or Ru	ral Route Number, C	City or Town, State, Z	ip Code)
_	1 an Heal em 2 thar		20a. Method of Disposition	IFE	20b. P	ace of Dispo	sition (Name of		-	TIMORE, ME	
Baltimore			1 X Burial 2 ☐ Cremation : '4 ☐ Dopation 5 ☐ Other (Sp.	ecity)		TIMOR		CEM. 5/1	1/2004	REISTERS	STOWN, MD
Ball	permit. Page Department of Important: If any injury or once.		21. Sand up of Funeral Service	nueu						N & BROS., KESVILLE,	
	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as	Sta a consequ	tie lence of):			or respiratory arrest		Approximate Interval Batween Onset and Death
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Records, F	w requires that the been signed by th should be detache	by	Part II. Other significant condition	s contributing to death b	ut not resu	Iting in the ur	nderlying cause g	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death? bably 4 □Unknown
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f Vital	dis X	To Be	25. Was case referred to medical examiner?	Hospital:	nt 2 🗆 E	ER/Outpatien	t 3□ DOA Ot	·	th (Check only one) ome 5 ☐ Residenc	e 6 □Other (Speci	fy)
on of	Jing After fune		27. Manner of Death  Autural 5 Pending 2 Accident investiga	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28c. Inju Wo M 1		28d. Describe how		
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be and Disco of Init	ury - At hos c. (Specify	me, farm, stre			28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	tha Hospit in 24 hour tha Funera pletely fille	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner sta	examinati	vledge, death on and/or inv	occurred at the trestigation, in my	me, date and place, opinion, death occur	and due to the caus	se(s) and manner as s and place, and due t	stated. o the cause(s)
	with 7	Σ	29b. Signature and title of certifier	paap	MA	)	29c. Licen	5 4 288	29d.	May 10	Day, Year) 2004
	γ,		Name and address of person w	no completed cause of de	eath (Item	23a) (Type, I	Print)	North 1	rest that	intal (	only
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 3 200	32. Registra	ar's Signati	(A)	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2004 **Physician** Billie Kay Lancaster MOU /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roseda Franklin Square Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JUNE 9, 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 220-36-5922 65 1938 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If time 27 is marked other than "natural; or tiems 23a or 28e-f show any injury or other traumatic event, it is Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Maryland | Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1134 Pulaski Highway #6 21162 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√7 No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 8 Elementary/Secondary (0-12) College (1-4or 5+) Barmaid 12 Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Lancaster UNK. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Cimino, Jr./Son 9524 Hallhurst Road Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 5-13-04 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD 299 Frederick Road Ba Ligaral Service Licentee Inc. Thomas Gregor ( Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anoxic Phalota **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a cons y uence of Examine use as the burial-transit and Due to (or as a consequence of) the attending physician Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**2** No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred To the Hospitel or Attending 1 Natural 5 Pending within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier n sorr who completed cause of death (Item 23a) (Type, Print) ive Baltimore, 9000 Franklin MICHORI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 3 2004

			For State Registrar	State of Maryl		partment of Hertificate of I			giene Reg. No.	2004	15362
	Dhusisi		1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea Month	ath Day	Year	3. Time of Death
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	the 286	Director	10e. Street and Number		Darca	10f. Zip Code			10g. Citiz	en of What Co	ountry?
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9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give		1 ☐ Yes 2 🛣No	Specify:	o nican, etc.)	- 1	Black, Whit	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar 8 State of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health Andread / Department / Department of Health Andread / Department / Department / Department / Department / Department / Department / Department / Department / Depa 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MAY 2004 4:00 P M LEISURE 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 7016 FIELDCREST ROAD N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 05/08/20 9. Birthplace (State or Foreign Months Days Hours Min. | Min. | Months Day 1830 | POLAND 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 185-26-4687 84 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ¥ Yes 2 ☐ No Directo BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 7016 FIELDCREST ROAD 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than College (1-4or 5+) TAILOR CLOTHING 17. Father's Name (First, Middle, Last)

Isaac Lieserowicz 18. Mother's Name (First, Middle, Maiden Surname) **LIESEROWICZ ESTHER** UNOBTAINABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ursula Wodarczy Leisure - Wife 7016 FIELDCREST ROAD BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State injury or \* 4 Donation 5 □ Other (Specify) BALTIMORE HEBREW 05/12/2004 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. any is 8900 REISTERSTOWN RD PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unhav Physician /Medical Due jo (or as a consequence of) Examiner nounic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit alter 194 Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 12 Yes 2 No 3 Probably 4 Unknown Completed 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has director, page 2 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this funeral 28d. escribe how injury occurred 27. Manner of Death 28b. Time of Certification: or Attending 1 Natural 2 Accident Injury after death investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person En, 20 IJT 4 000 lilan 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien \( \text{O} \) \( \cdot \) \.

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H	Funeral		5. Social Security Number 213-68-0155	3. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs 101	. last birthday) Yrs.	Months	er 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th ly, Year A 1	9. B	irthplace (State or Country) Choslova	Foreign
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Division of Vital Records,	requires that been signed b hould be deta	d by	Prouvonia	- <u>;</u> (	aron	ory	av	en	dis	ON,	10	Yes 2	.□No 3□F	Probably 4 Defi	known
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ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical						26. Place	of Death	(Check only o		, , ,	3 245110	
Ž >	S &	To	examiner? 1  Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 🗆 🗆	Othe Othe	4 D Nu	rsing Hor	ne 5∐Resid	dence	6 □Other (Sp.	ecify)	
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	the Ho hin 24 t the Fu npletely	edical	(Check only 2 Medical E	xaminer: On the b and man	asis of examin ner stated.	ation and/or in	vestigatio	n, in my op	oinion, deat	th occurre	d at the time,	date an	d place, and du	e to the cause(s)	
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,			1415	101)				10-	38	75	4	03	>- (0 -	2006	t .
	3		30. Name and address of person w	ho completed caus	se of death (Ite	m 23a) (Type,	Print)	40-	00.	1 1	BLUD		1110	- 717	21
			31. Date filed (Month, Day, Year)	1 13/2/2//	legistrar's Sign	TU TO	200	1-1		4 2	JU 1)		110	- 414	-1.
	Sta Registr		MAY 1 3 2004	Caribo		PA	3								

DHMH 17 Rev 1/2001

Deborah Lloyd 04-02955 RPD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death

15365

<b>Physician</b>	
/Medical	
Examiner	

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.

Phys /Me Exa

To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

	Registrar  1. Decedent's Name (First, Middle, Las	*1			Death	2. Date of De	Reg. No.	_	2 Time of Deep	
n al.	DERODA /	LOYD				Month May 1	Day	Year 4	3. Time of Deat	
ıı. r	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death			County of Death		
	Sinai Hospital			Baltimo						
	213-70-5139	7. Age (In yrs.	(Ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th 19, Year) 20,196	9. Birth Cou	place (State or Form	
	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Lin	
Director	MD ANNE AR	UNDEL PA	SADE	NA					1 ☐ Yes 2 😿	
3	10e. Street and Number	1	ب در د	10f. Zip Code			10g. Citiz	en of What Cou	intry?	
ŝ	615 lowhATTON B	EACH RD.		21	122		(	0.5.	A.	
	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No Rican, etc.)	)- 1	<ol> <li>Race - Ameri Black, White</li> </ol>		
2	1 Never Married 2 Married 3 Widowed 4 Divorced	1	1	☐ Yes 2 No	Specify:			Specify:	TE	
	15. Decedent's Ed (Specify only highest grad		16a. Deced	ent's Usual Occupa	ition	kina	16b. Kin	nd of Business/Ir	ndustry	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	O NOT use retired)	aring most of wor	uig	بر ن	Den	. ^ - 1	
	17. Father's Name (First, Middle, Last)		1011	anager	18. Mother's Nam	o /First Middle	Maidan	KESIC	PRATION	
	ERNIE MORL	An1			FOMI	1 -	, maiden s	oumame)		
2	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street a	nd Number or Ru	NICE ral Route Numb	er, City or	Town, State, Zi	p Code)	
1	JERRY LLOYD, HU	SBAND	615 8	whatton	REACHR	b. ASAD	ENA.	MD.ZII	22	
1	20a. Method of Disposition	1 6	Place of Dispos	sition (Name of patory or other place		Date		cation - City or T		
	1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		NIEW	"REMATOR	5-8-	-04	BALTI	MORE, A	ND.	
	21. Signature of Funeral Service Licen	666	22	Name and Addres	s of Facility amily Funeral H				- 2	
	A. M. Wan	wx >		2601	Mountain Road	Pasadena	MD 21			
	23 . Part1. Enter the diseas of consistence, or heart failure. List only of	he hons that remised life death one cause on each line.	h. Do not ente	er the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)  A. Pulwowing thromboeunbolism  Due to (or as a consequence of):  Bilartral duer vein throm bosis  Bilartral duer vein throm bosis  Bilartral duer vein throm bosis									
	ſ	Bulland	uence of):	in Veli	+6,	nu bo	2'12			
	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq		y reac	, , , , ,	000	-/ -			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							11		
LAGIIIIIC	resulting in death) Last	Due to (or as a conseq	uence of):							
200		d								
ā l	IF FEMALE:							l .		
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	23b. Was decedent pregnant	23c. If yes, out <i>co</i> me of pregna 1☐Live birth 2☐Feta	Ideath 3□	Ectopic pregnancy			2:	3d. Date of deliv	,	
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State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 3 2004

7. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien ? 15366 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month .Physician 625 AIN CUN JR. Moy 4b. City, Town, or Location of Death 2004 11 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 100 Medica **Baltimore** N/A 6. Sex 1**2** M 2□ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Hours Months 75 220 20 2711 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Merylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f ehor the Medical Examiner must be notified at 1⊠Yes 2□No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3915 Inner Circle 21225 U.S. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 K No Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Laborer A & P Tea Company 4th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be nant of Health end Mental Charles Linthicum Sr. Florence Nagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 384 Church Street Vicky Schertle / Daughter Glen Rock, Pennsylvania 17327 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 5/13/04 Baltimore, Maryland 22. Name and Address of Facility 21. Signa are of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Baltimore, Maryland 21225 Part1. Enter the dis se, and shock, or heart failure. List of Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequ Physician/Medicai Examiner 5 or Attending Physician: The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that in the total or the conditions of the condi Due to (or as e consequence of) P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Be Completed by funaral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Natural

Accident Injury 5 Pending 1 Yes 2 🗆 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A investigation tha 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) complataly filled in by 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (dem 23a) (Type, Print) Plice # 815 renzer U M.P. 2120 32. Registrar's Signature State Registrar

			For State Registrar		State o	f Maryla	and / Dep <i>Ce</i>	artmen ertificat				lental Hy	giene Reg. No.	004	15367
>	Physici /Medi	cal	1. Decedent's Name	-0n	, Last)	L mber)	eor	Ah City	Town or	Location	of Dooth	2. Date of De Month	eath Pay	Year Year	3. Time of Death
	Examir Funeral Director	ner	5. Social Security N 217-30-4	lumber V	6. Sex 1 M 2 F	Ct f 7. Age (In y	Tanta Janta	1/	30	If Under Hours	20	8. Date of Bi Month, D.		9. Bir	thplace (State or Foreign ountry)
	pu »		Usual Residence of 10a. State		^		City, Town or L	ocation				11/20/	1330		
	the Marylan 28a-f show notitied at	tor	MD	,	/A		ALTIMOR								10d. Inside City Limit
	or 28;	Funeral Director	10e. Street and Nu	mber				10f. Zip	Code		-		10g. Citiz	zen of What Co	ountry?
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21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28a-1 show or other treumetic event, the Modical Examinat must be notified at	by	11. Marital Status  1 Never Marr 3 Widowed	4 Divorced	If es, Giv Year or D	rces? 2  No ve		1 ☐ Yes	2 No	Specify:		ecify Yes or No Rican, etc.)		Black, Whi	erican Indian, le, etc. ITE
15-	in 72 h	Completed			t grade completed)		16a. Dece (Give	edent's Usua kind of wor DO NOT us	al Occupa rk done d se retired	ation <i>luri</i> n <i>g m</i> os )	t of worki	ng	16b. Kin	nd of Business	/Industry
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Maryland	ould be file Mental Hy arked oth	To Be (	17. Father's Name  JOSEPH	(First, Middle, i	Last)		1.1	EON		18. Mothe		(First, Middle	, Maiden S	,	FINE
lary	2 should and Men is marke eumetic	-	19a. Informant's N	ame/Relationsh	nip (Type, Print)		19b. Mail	ing Address		nd Numbe	er or Rura			Town, State,	
	1 and 2 Health tem 27		JAMIE LE		PHEW	201			100.000	DR.	10000000	TERSTON	_		
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Dis Burial 2	Cremation	3 Removal from	State B	Place of Disp ETH YEH	DDA A	SHE	9)		ate		cation - City or	
Ħ			' 4 □ Donation	5 ☐ Other (Spineral Service	A 1/	K	JRLAND			.0	5/12	/2004	BALT	IMORE,	MD
Ã	permit. Departn Importe any inju		XIII	West !	Sun	4_	8	900 RE	EISTE	RST0	'SUL Wn ri	LEVINS D. PIKE	SVILI	BROS.	) 21208
fi			23a. Part1. Enter t shock, or hea	he disease, or rt failure. List	complications that conly one of ase on e	aused the de	eath. Do not en	ter the mode	e of dying	, such as	cardiac o	r respiratory a	rrest,	,	Approximate Interval Between
}	Physician		Immediate Cause disease or condition resulting in death)	(Final	a	C	060	M		(	A	NCE	R		2 GOUN
	/Medical Examiner		resulting in death)		Due to (	or as a cons	equence of):								
	4	Jer	Sequentially list con any, leading to in cause. Enter Under Cause (Disease or	nditions, nmediate	b. Due to (	or as a cons	equence of).			_					
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	3	с										
60,	ficate be execute physician and s the burial-trans	ai Ex	resulting in death)	Last	Due to (	or as a cons	equence of):								
68760,		edicai			d										
О. Вох	at the death certifi by the attending i tached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2  9  Unknown	months?		irth 2 □ Fi ant at time o	etal death 3[	⊒Ectopic pre □ Other (spe					23	3d. Date of del Month	ivery Day Year
ords, P	w requires that the been signed by the should be detache	by	Part II. Other signif	icant conditio	ns contributing to de	eath but not r	esulting in the u	inderlying ca	ause give	n in Part I.		23e. Did t	1		the cause of death?
Vital Records,	The law ate has b page 2 st	Completed	05.146									24a. Was autop perfo 1 Yes	2 No	24b. Were au prior to death? 1 ☐ Yes	topsy findings available completion of cause of
Ξ	Phyeicien: this certific ral director,	o Be	25. Was case refer examiner?	No medical	Hospital:	mpatient 2	☐ ER/Outpatie	nt 3 DO	Othe	_		Check onl		□Other (Spec	nife)
on of	ding Ph h. After th funeral	lon; T	27 Manner of Deat	5 Pending			28b. Time o	f 28	Bc. Injury Work	at ?	2	8d. Describe			ary)
=	Atten er deat ector: by the	Certification;	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investig 6   Could n determi	ot be 28e. Place	of Injury - At ng, etc. <i>(Spe</i>	home, farm, st	M reet, factory,		es 2 □ l		8f. Location (S City or Tox	Street and vn, State)	Number or Ru	ral Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edicai (	29a. Certifier (Check only one)	Certifying	Physician: To the xaminer: On the ba and mann	isis of exami	nowledge, deat nation and/or in	h occurred a vestigation,	at the time in my opi	e, date and inion, deat	d place, a	nd due to the	cause(s) a date and p	ind manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier		A.		29c.	License	number			29d. Date	signed (Month	n, Day, Year)
	1		) a	us, l	2 The	47	200	7	PII	77	9		51	10/19	7
	5		30. Name and addr	of person y	ho mpleted cause	e of death (It	ет 23а) (Туре,	Print)		1	6	7	>	1	11
			31. Date filed (Mon.	th Day Year	Vienta	egistrar's Sig	S Sc	wth	0	reci	ne	DT, 15	alth	nol	IVI)
M	Sta Registr		MAY 1	3 2004	Bene	ogistiai S 319	& A	m v		i.		r			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien O.O.

			1 - For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of H rtificate of I			C 0.07	15358
	ġ		Decedent's Name (First, Middle	e, Last)				2. Date of Deat		3. Time of Death
	Physici /Medic		Snell		McGr	iff, Jr.		Month 5 8	Day Year 2004	8:p M
	Examir		4a. Facility Name (If not institution				Location of Death		4c. County of Death	
			1538 Homesteat	: St.		Baltimore				
	Funeral Director		5. Social Security Number 259–28–6614		ge (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3-10-2	Year) 9. Birth Cou	place (State or Foreign ntry)
Т	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				104 1-14-05 11 5
	Aaryla F sho	ō								10d. Inside City Limits  1∑Yes 2 □ No
	289-	Director	Md. NA	A	Balti	10f. Zip Code		10	g. Citizen of What Cou	
	3a or	٥	1535 Homestead	Ctreet			2121			nu y :
	ter death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi	2121 spanic Origin? (Span, Mexican, Puerto		USA 14. Race - Amen	can Indian,
21215-0036	72 hours after death with the Maryland "naturel", or Items 23a or 28e-f show offical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied Armed Forces?  1 ☐ Yes 2  If Yes, Give  Year or Dates:	No	f Yes, specify Cuba I□Yes 2॑र्रू No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	etc. .ack
2-0	72 ho natur	Completed	15. Deceden (Specify only higher	t's Education	16a. Deceo	lent's Usual Occupa	ation	1	6b. Kind of Business/In	dustry
21	c *_ @	nple	Elementary/Secondary (0-12)	College (1-4or	life /	KING OF WORK GONE O DO NOT use retired	furing most of works )	ing		
21		Con	6th grade 17. Father's Name (First, Middle,		S	teel Mill			Bethlehem	Steel
Maryland	bed late	Be		Last)			18. Mother's Name	e (First, Middle, M	,	
ž	d 2 should by th and Menta 7 Is marked treumetic ev	ပ္	Snell 19a. Informant's Name/Relations	hin (Tuna Briat)	McGriff, S		Sally	10	Tillman	
Ma	har har 7 Is		Viola McGriff		1				City or Town, State, Zip	_
	is 1 and if Health item 27 other tr		20a. Method of Disposition	Wife	20b. Place of Dispos	sition (Name of	ad St., Ba		<ul> <li>Md. 2121</li> <li>Oc. Location - City or To</li> </ul>	
e E			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 ☐Removal from State		natory or other place	5–17-	-04	Baltimore,	МА
Baltimore,	in particular		21. Signature of Funeral Service		Greenmou	nt Cem. . Name and Addres				
m	Depa Impo eny i		1 Dlac	lus Wan	M	arch F.H.	East		. North Ave	21202
版	Physician /Medical Examiner	-	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a Due to (or as	a consequence of):	ME	Le Ma		(2	Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner	Sequentially list conditions, I am leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
.O. Box	death cer e attendir d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
rds, P	w requires that been signed should be del	þ	Part II. Other significant condition	ns contributing to death b	ut not resulting in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contribute to th	ne cause of death? ably 4 Unknown
Record	2 38	Completed		-			<del></del>	24a. Was an autopsy performs	prior to cor death?	psy findings available appletion of cause of
Vital	ding Physicien: The h.h. h. After this certificate ha funeral director, page	Be (	25. Was case referred to medical examiner?				26. Place of Death			7-3110
<del>o</del>	hysi this c	2	1 ☐ Yes 2 No	Hospital: 1  Inpatie			4 - Nursing Hon	ne 5 Aesiden	ce 6 ☐Other (Specify	')
N U	ling F	on:	27. Manner of Death 1 Pending 5 □ Pending		28b. Time of Injury	28c. Injury Work	?	28d. Describe how	injury occurred	
isi	death death stor: ,	icat	2 Accident investig	ot be	un. At home form stee		es 2□No	006 Lanation (Chr.	-1	
Division	l or Atten after deatl Director: I in by the	Certification:	4 ☐ Homicide determi	building, etc	ury · At home, farm, stre c. (Specify)	ет, тастогу, опісе		City or Town,	et and Number or Rura. State)	l Houte Number,
_	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funerel.	edical C	29a. Certifier (Check only one) Medical E	g Physician: To the best of xaminer: On the basis of	examination and/or invi	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	and due to the cau	se(s) and manner as stee	ated. the cause(s)
	o the o the omple	Med	29b. Signature and tale of certifier	and manner sta	ned.	29c. License			L Date signed (Month, L	
	- S + 0		Your	nd 0	کے	DZ			1	
	り		30. Name and address of person with ANANDA K	M34NAI	V 621	NIEUZ	AW 57	BAL	5/10/0	M 3/201
•	Stat Registra		31. Date filed (Month, Day, Year)  MAY 1 3 20	2 1	ar's Signature	1 .				

DHMH 17 Rev 1/2001

SWELL MCGRIFF

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Year **Physician** May 11, 2004 6:00 P M Vera Wenk Mays /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Collingswood Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/28/1924 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2ĂF 579-24-4549 79 Maryland Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "netural", or itams 23s or 28e-f show treumetic event, the Medical Examinar must be notified at MD Montgomery Rockville Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20853 U.S.A. 13504 Oriental Street death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Baltimore, Maryland 21215-0036 Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest Colon Wenk Gertrude L. Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13504 Oriental Street, Rockville, Maryland Donald Mays / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 1 Burial 2 Cremation 3 Removal from State ò Department of Important: If any injury or once. 05/13/2004 Laurel, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Balt-Wash Crematory 21. Signature Funeral Service Licensee 22. Name and Address of Facility  $Fleck\ Funeral\ Home$ , Inc.401338 enya De wart 7601 Sandy Spring Road, Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) emer Physician Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 moeths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 Yes 2 No 3 Probably 4 Onknown 000000012 Completed peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To tha Funaral Diractor: After this certifics completely filled in by the funeral director. I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) X completed cause of death (item 23a) (Type, Print) even 110515 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 3 2004

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

				arylan	Certific				Reg. No.	04	15370		
Physiciar /Medica	n al _	Decedent's Neme (First, Middle, La Ernest M. Maulb	etsch				4b. City, Town, or	2. Dete of De Month	Dey 1 2	Yeer 2004	3. Time of Death 1:20 A.M		
Examine Funeral Director	5	. Social Security Number 6. 5	Apt 2501	Apt 2501, 8800 Walther. Blud  ox 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs						Ltimo 9. Birthpl Count	ፓር ace (State or Foreign rry) ከጠዉክሀ		
f show	1	Oa. Stete 10b. County  Md. Baltin	ata	10c. City	, Town or Location  Baltimo	H O		, ,,,,		10	Dd. Inside City Limits 1 ☐ Yes 2√☐ No		
death with the Maryland rms 23e or 28a-f show rmust be notified at	=   '	Oe. Street end Number  8800 Walther Blvo		01		Zip Code 212	34		10g. Citizen of USA	What Count			
urs efter	2	Maritel Status     □ Never Married 2 Married     3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 If Yes, Give Year or Dates:	7		cedent of I pecify Cub	lispenic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	o- 14. Ra Bla Specil	ce - America ck, White, e by: Whi	etc.		
7 5 6 6	Сотріете	15. Decedent's E (Specify only highest gre Elementary/Secondary (0-12) 12 7. Father's Neme (First, Middle, Lest	de completed) College (1-4or	5+)	16a. Decedent's U (Give kind of life. DO NOT	work done Tuse retire	during most of wor d)		16b. Kind of B	Postal	service		
Baltindore, Maryland 212: permit. Peges 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: if item 27 is merked other than once.	0	Martin Maulbetsch  Wilhelmina (surname unknown)  19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)											
dore, N eges 1 and in of Health it: if item 27 y or other tr		Roy Maubetsch/Sc  Oa. Method of Disposition  1 Burial 2 Sicremation 3 C	Removal from State	20b. Pla	ace of Disposition (formetery, crematory of	vame of or other place	сө)	Date	20c. Location	City or Tov			
Baltindore) permit. Peges 1 a Department of He important: if item eny injury or othe once.	1	4 Donation S Other (Specify)  Bayview Crematory  5/13/2004 Baltimore, Md.  21 Signature of Funeral Sovice Usansee  22 Name and Address of Facility  Schimunek Funeral Homes  610 W. MacPhail Rd., Bel Air, Md. 21014											
Physician /Medical Examiner	į	23a. Pan 1. Enter the disease, or com- prock, or heart failure. List only mmediate Cause (Final disease or condition esulting in deeth)	a	A	. Do not enter the m		ng, such as cardiad	or respiratory a	irrest,	V	Approximate Interval Between Onset and Death		
68760, tificate be executed g physician and as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest  Due to (or as a consequence of):  Due to (or as a consequence of):										<i>feas</i>		
The law requires that the death cert are has been signed by the attending page 2 should be datached for use.	leted by rillysicially	eart II. Other significent conditions of	1 🗆	tobacco use co Yes 2□ No an autopsy med?	3 ☐ Proba	re autopsy findings ilable prior to ipletion of cause							
of Vital Records, Physician: The law requires the certificate has been signed in director, page 2 should be completed by		5. Was case referred to medical					26. Place of Dea	th (Check only o	Yes EJUU		eath? Yes 2□ No		
Division of Vital Rec to the Hospital or Attending Physician: The law within 24 hours efter death. To the Functel Director: After this certificate has completely filled in by the funeral director, page 2	2	examiner? 1	28a. Date of Inju (Month, De	iry :	ER/Outpatient 3 28b. Time of Injury	28c. Injur Wor	Wursing H		dence 6 □Oth				
Division Completely filled in by the funers  Medical Contification.		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined	building, et	c. (Specify)				City or To					
To the Hospi within 24 hou To the Funer completely fil		(Check only 2 Medical Exam	ysician: To the best of niner: On the besis of end manner ste	fexamination	on end/or investigati	on, in my o	pinion, death occur	rred at the time,	date and place,	and due to	the cause(s)		
To the Common Co		9b. Signature and title of certifier	1 mo			9c. Licens	e number		29d. Date signe	d (Month, D	2004		
<u>l</u>		O. Name and address of person who a  JCCA London	0043	Wa	lthe P	1.7	Part	ille y	NO 21	234			
State Registrar		1. Dete filed (Month, Dey, Yeer)  MAY 1 3 2004	32. Registro	ers Signeti	A for	4.							

DHMH 16 Rev 6/95

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State of Maryland / Department of He	ealth and Mental Hygiene C O I

			1 - State of Maryland / Department / Department / Department / Department / Department / Departm	artment of Health and Mental Hygie rtificate of Death	COM CO. 1. 10. 10. 1. 1
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Estella	2. Date of Death Month	Day Year 7 12 PM
	Examir Funeral		4a. Eacility Name (If not institution, give street and number)  5. Social Security Number  6. Sex 1 M 2 X F 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Lif Under 1 Year If Under 24 Hrs.  Months Days Hours Min. (Month, Day, Year)	4c. County of Death
	Director		224-44-8825	03 09	31 NC
	death with the Maryiand ms 23a or 28a-f show	ector		ore	10d. Inside City Limits  XXYes 2 □ No
	3a or 3	i Dir	10e. Street and Number 3805 Monterey Road	10f. Zip Code 10g.	Citizen of What Country?
36	72 hours after death with the Maryian natural; or Itams 23a or 28a-1 show disal Examinar must be inclifted at	by Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc.
21215-0036	in 72 hour n *natural	Completed b		dent's Usual Occupation 16th kind of work done during most of working DO NOT use retired)	Black b. Kind of Business/Industry
1212	ges 1 and 2 should be filed within .  1 of Health and Mental Hygiene.  If item 27 is marked other than " or other traumatic event, the Mac	Com	Elementary/Secondary (0·12) College (1·4or 5+)  11th grade na Nt  17 Fotbate Name (First Middle / act)	ırse Pr	civate Duty
Maryland	uld be fi dental H rked otl	To Be	17. Father's Name (First, Middle, Last)  Leonard Franklin	18. Mother's Name (First, Middle, Main  Ida Mae Beachma	
Mary	d 2 shouth and N 7 is material	1 13	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rural Route Number, Ci L6th Street, Virginia E	
	jes 1 and 2 of Health a if item 27 is or other tra		20a. Method of Disposition 20b. Place of Dispo		Location - City or Town, State
Baltimore,	t. Pa rtmen rtant: njury		'4 Donation 5 Other (Specify) King Men	norial Park 5/15/04 Ra	ndallstown, Md
Ba	Depa Impo any ir			Name and Address of Facility  BOO Wabash Ave, Baltimo	ore Md 21215
	Pirysician	9 3	23a. Part 1. Enter the disease or complications that ceused the death. Do not enter shock, or heart failure List only one cause on each line.  Immediate Cause (Final disease or condition	er the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):		
68760,	ificate be executed p physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a ecosequence of):  c. Due to (or as a consequence of):  d.		
O. Box	ath certif ttending or use as	Physician/Med		Ectopic pregnancy	23d. Date of delivery Month Day Year
<u>a</u>	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions contributing to death but not resulting in the ur	The state of the s	2 No 3 Probably 4 Minknown
of Vital Records,		Completed by	Breast Cancer	24a. Was an autopsy performed 1 \sum Yes 2	
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (Check only one) t 3 DOA Other: 4 Nursing Home 5 Residence	C = 04h (0
ion of	nding Phy ath. r: After this ie funeral c		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Injury	28c. Injury at Work?  M 1 Yes 2 No	
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.	Certification:	3 ☐ Suicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office 28f. Location (Street City or Town, Str	and Number or Rural Route Number, ate)
	e Hospi 24 hou e Funer etely fill	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invariant manner stated.	occurred at the time, date and place, and due to the cause restigation, in my opinion, death occurred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	Δ	Date signed (Month, Day, Year)
r	M		30, Name and address of person who completed cause of death (Item 23a) (Type, I	KES-000 M	
	J		Avian Kidd MD 2401 West	Belvedere Dene Balton	ine Maylon 21215
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 3 2004  32. Registrar's Signature	alls!	-

		4	1 - For Amend Item 26 p	er Dr.,6831,0	5/1/3/0	diBepa Cei	artment of rtificate of	Health a	and Me	ntal Hy	giene Reg. No.	004	15372
			1. Decedent's Name (First, Middle, L	_ast)					2.	. Date of Dea	ath Day	Year	3. Time of Death
Physi /Me		_	Janice	White	N:	ichols	on			May	10,	2004	4:20 p M
Exan			4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town,	or Location of	of Death		4c.	County of Dea	th
			5 Firefly Circl	e, apt. H				ysvill				Baltimo	ore
Funer	al		Social Security Number 6.	Sex 7. Age	(In yrs. la	ist birthday)	If Under 1 Yea Months Days		24 Hrs. 8. Min.	. Date of Birl (Month, Da	th ly, Year)	9. Bir C	thplace (State or Foreign ountry)
Directo	or		216-20-6874	ILIM ZWIF	78	Yrs.				Ian 28			ryland
pu »		+	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	eation						10d. Inside City Limits
aryla		_	Toa. State		roo. Only,		Cation						1 ☐ Yes 2 📉 No
86-1		<u></u>	Maryland Baltim	ore		Towson							
with to	1	5	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What C	ountry?
ath v		Funerai	305 E. Joppa Roa			140		1286			US.		oten ballen
er de itam		<u> </u>	11. Marital Status	12. Was Decedent E Armed Forces?		. 13.	Was Decedent of f Yes, specify Cu	ban, Mexicar	n, Puerto Ric	can, etc.)		<ol> <li>Race - Ame Black, Whi</li> </ol>	
rs aft	l'	و ۲	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 1 ☐ Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	O		1 □ Yes 2 <b>X</b> No	Specify:				Specify:	White
Pour Italia		90	15. Decedent's		1	16a. Dece	dent's Usual Occi	unation			16b. Kir	nd of Business	
in 72		Completed	(Specify only highest of	grade completed)		(Give	kind of work dan DO NOT use retir	e durina mos	t of working				,
with ene.		Ē	Elementary/Secondary (0-12)	College (1-4or 5 n/a	+)	Bo	okkeepe	r			R	eal_Est	ate
filed Hyg Sther	9	as I	17. Father's Name (First, Middle, La		-		ORRECPE	1	er's Name (F	First, Middle,			
yionic X 1 X 13-0030 oud be filed within 72 hours after death with the Maryland Mental Hygiene. Rickd other than "natural", or itama 23a or 28e-f show atte event, the Medical Exercise ment be motified at	1	0	Arthur Gantt	White				Edi	th .	Fer	n	Wo11	F
2 should and Men Is marke aumatic	T)	-  -	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Stree					1,02.	
2 0 0 = 8			Robert Lee Nicho	leon/Son		5 F	refly C	ircle	ant	н Со	ckow	ewillo	MD 21030
ges 1 and 3 1 of Health If item 27 or other tr			20a. Method of Disposition	18011/3011	20b. Pla	ace of Dispo	sition (Name of	-	Date	9	20c. Loc	ation - City or	Town, State
ages ant of y or			1 ☐ Burial 2 🂢 Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of Cont				natory or other pl e-Washin		5/13/0		Lour	el, Mai	extland
artme porten injur	mi l	+	21. Signature of Funeral Service Lic	1111	THE STATE OF	1 22	Name and Add	ress of Facilit	h				•
permit. Pages 1 Department of H Importent: If Ite eny injury or ot	once		Bryan W. Cla	( Levy		, T	emmon Fu	ıneral	Home	of Du	lane	y Valle	y Inc.
_			23a. Part1. Enjar the disease, or co shock, o heart failure. List on	-	the death.		U W. Pader the mode of the					MD Z	Approximate
			shock, or heart failure. List on Immediate Cause (Final				( )						Interval Between Onset and Death
Physicia /Medica	_		disease or condition	a Pulu	none	any 5	Hibrosi	2	-				5 years
Examine	_			Due to (or as a	a conseque	ence pt):							60
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	conseque	ence of):					_		
nsit Lie	-		Cause (Disease or injury	rese									
ai-tra		Examiner	that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):						_	
ate be executed the burial-transit	-	cal		4									
ficate ficate phy:	1	900		d.									
v requires that the death certifies been signed by the attending pt should be detached for use as the	1	Pnysician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	3d. Date of de	livery
atter of for o		clai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			]Ectopic pregnan ] Other (s <i>pecify</i> )	су				Month	Day Year
the cy		S	9 Unknown	9□ Unknown									
that that			Part II. Other significant conditions	contributing to death but	it not resul	lting in the u	nderlying cause g	oven in Part I.		23e. Did to	obacco us	e contribute to	the cause of death?
requires I	1	a by	Caronany o	Ary di	ugo	e_				121	Yes 2□	]No 3 □ P	robably 4 Unknown
should be should		lete								24a. Was	an	24b. Were at	utopsy findings available
ne la ne la s has ge 2		Completed								autop perfo	rmed?	prior to death?	completion of cause of
ding Physician: The law her had had had had had had had had had had	(	3	25. Was case referred to medical						15 11 11	1 Yes		1 ☐ Yes	
Sicial certi	(	מ	examiner?	Hospital:		7/0				Check only o		<b>X</b> (0	Son's Residence
ding Phys	.   1	0	1 Yes 2 No  27. Manner of Death	1 ☐ Inpatie		R/Outpatier 28b. Time of				d. Describe h			city) Nestuciae
ding h. Afte			1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injur (Month, Day	Year)	Injury		ork? ∐Yes 2.⊟l	No				
deal deal ctor.		Certification;	3 Suicide 6 Could not	be 28e. Place of Inju	ry - At hor	ne, farm, str	eet, factory, office	9	281			Number or Ri	ural Route Number,
after Dire	1	era	4 Homicide	building, etc	. (Specify)		, , , , , , , , , , , , , , , , , , , ,			City or Tow	vn, State)		
apita nours nerei			29a. Certifier 1 Certifying	Physician: To the best of	f my know	rledge, deatl	occurred at the	time, date an	d place, and	d due to the	cause(s) a	and manner as	s stated.
e Ho 24 } e Fui	:	edical		aminer: On the basis of and manner sta	examination								
To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	:	Z e	29b. Signature and title of certifier	11:/				nse number			29d. Date	signed (Mont	h. Day, Year)
- > - 0			> // o / //	/ -/ (	/	11	07	068	8		4	5/12/1	54
11		-	30. Name and address of person with	a completed cause of	ath (Henr	23a) (Type.	.,					1 . / 6	1
-	}		Carl Friedman,	V			ve., su	ite 310	0. Tow	son.	MD '	21286	
	State	e	31. Date filed (Month, Day, Year)	32. Registra		ψe	/						
Regi			MAY 1 3 2004	Bens	1	1 A	souls						

	-	State of Maryland / Department of Heritage	ealth and M Death		ene2 0 0 4	15373
Physicia	-	1. Decedent's Name (First, Middle, Last) Louis Nerf		2. Date of Death Month	Day Year 2004	3. Time of Death 9:30 A M
/Medica Examine		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or  Johns Hopkins Bayview Medical (either  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday). If Under 1 Year	Baltom  If Under 24 Hrs.	wre	4c. County of Deat	
Funeral Director		217-03-9086 1 XM 2□F 86 Yrs. Months Days  Usual Residence of Decedent	Hours Min.	May 16,	1917 Mari	intry) Iland
Maryland a-f show	TOL	10a. State 10b. County 10c. City, Town or Location  Maryland Baltimore Baltimore				10d. Inside City Limits 1 ☐ Yes 2 No
with the	Director	10e. Street and Number 4200 Garland Avenue	2123		g. Citizen of What Co	untry?
	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 X No			14. Race - Ame Black, Whit	e, etc.
other, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10th Grade  16a. Decedent's Usual Occupa (Give kind of work done dilife. DO NOT use retired)  Conductor	tion uring most of work	ding 1	6b. Kind of Business/	·
be file tat Hyg d othe	o ne		18. Mother's Name Helei	e (First, Middle, M N Zork	aiden Surname)	
MC dd 2 sl		19a. Informant's Name/Relationship (Type, Print)  Mrs. Lois Loewer (daughter)  4200 Garland			-	
Pages 1 an nent of Heal ant: If item 2 ury or other	-	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	<b>ə</b> )	Date 2	Oc. Location - City or	Town, State
Dallillor permit. Pages Department of Important: If it eny injury or o		14 □Donation 5 □Other (Specify) Oak Lawn Cemetery 21. Signature of Funecal Service Licensee 22. Name and Address	s of Facility Sc	himunek F		nes
Physician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a Concestive Heart F	g, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death
/Medical Examiner	a	Immediate Cause (Final disease or condition resulting in death)  a. Condetified The Theory Th	ease			33 years
por por	dical Examine	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
death certific	nysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of deli Month	very Day Year
es tha igned l	y	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give History of Ventnicular fibrillation status	-		cco use contribute to	
	Сотрыете	Automated Implantable Careliac Defibrillator, Mellitus, History of Prostate Cancer	Diabete	24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
sicien sicien irector	0 0	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:   Linpatient 2 ER/Outpatient 3 DOA Othe		h (Check only one)	ce 6 ☐Other (Spec	ufu)
D € € ½ C	ation:	27. Manner of Death 1		28d. Describe how		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
ne Hospif ne Hospif ne Funer oletely fill	edical	29a. Centifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time 2 Medical Exeminer: On the basis of examination and/or investigation, in my op and manner stated.	e, date and place, inion, death occurr	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
To the within To the comp	M	29b. Signature and title of certifier 29c. License			d. Date signed (Month	2004
7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Christine Lee, 4940 Eastern Avenue, B	altimar	1 M	200	4
State Registra		31. Date filed (Nonth, Day, Year) MAY 1 3 2004  32. Registrar's Signature  Sacistic		, , , ,	e : ar au	

			1- For State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 1 5 3 7 4  Certificate of Death Registrar								
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death								
	Funeral Director	•	Pull-more Rehabilitation Through Care Bultonics n/a  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15. Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 288-14-2587 78 78 78 78 78 78 79 78 79 78 79 79 70 70 70 70 70 70 70 70 70 70 70 70 70								
	show	J.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  Maryland n/a Baltimore 10XYes 2□No								
	with the M a or 28a-f be reciffi	Direct	10e. Street and Number 100 North Athol Avenue 10t. Zip Code 21229 10g. Citizen of What Country? United States								
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examinatinust be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married 3 Midowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 News Packet Married 2 Married 3 Midowed 4 Divorced  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1 News Packet Middle News Packet Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Yes, Specify: Specify: White								
21215-0036	d within 72 ho giene. sr than "natur The Wedical.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  United States  military service member								
	ould be filed Mental Hygis tarked other tatic event, II	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)								
Maryland	2 should I and Men Is marke	ပို	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
	es 1 and 3 of Health fitem 27 r other tr		Veronica O'Brien - sister  100 North Athol Avenue, Baltimore, Maryland 21229  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State								
altimore,	Pag nent ant: I ury o		New Cathedral Cemetery May 14, Baltimore, Maryland								
Bal	permit. Departi		21. Signature of Funeral Service LibertSee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229								
	/Medical Examiner	er	23a. Part1. Enter the disease, or communications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between One at and Death disease or condition resulting in death)  a. — (If the following of the consequence of figure 1) and the consequence of figure 2) and the consequence 2) and the con								
8760,	ate be executed hysician and the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d								
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1  Ectopic pregnancy 23d. Date of delivery Month Day Year								
ords, P	v requires that been signed t should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown								
al Records,		Completed	Chrome Gatractive Manorem Discrete 24a. Was an autopsy performed?  1 Yes 20 No 1 Yes 2 No 1 Yes 2 No								
f Vital	Physician: this certificatal director,	To Be	25. Was case referred to medical examiner?  1  Yes No								
on of	Jing After fune		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No								
Division	or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To th withir To th comp	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)								
•	141		Augustin Chiffi m. D. 18298 may 11, 2004  30. Name and address of person who complete grouse of death (Item 23a) (Type, Print)  AUGUSTIN CHYU 3900 Loch Paven Blvd Baltimore 1/19 2/2/8								
	Sta	to	AUGUSTIN CHYU 3900 Loch Raven Blvd Baltimore 1/19 2/2/8  31. Date filed (Month, Day, Year)  32. Registrar's Signature								
	Registr		MAY 1 3 2004 Senate & Sports								

State of Maryland / Department of Health and Mental Hygiene 2004For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2004 PEYSER MARGARET MAY /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth **Examiner** Randallstown Baltimore Northwest Hospital Center

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□ M 2□F 215-12-1394 83 Yrs. August 19,1920 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-fahow the Medical Examiner rount be notified at 1 Yes 2 □ No Director N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ö 3041 Fallstaff Road, #605-D 21209 23a United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itams 11. Marital Status filed within 72 hours after 1 □ Yes 2 □ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXo Specify: White þ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) other than Elementary/Secondary (0-12) Office Clerk City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) rmit. Pages 1 and 2 should be file partment of Health and Mental H-portant: If item 27 is marked oth y injury or other treumatic avan Reinholt Schaefer Elizabeth Falk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren Hudgins Daughter 3955 Nemo Road, Randallstown, MO. 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ege repartment of Important: If its 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Baltimore-Washington Crem. 05/14/04 Laurel Maryland 22. Name and Address of Facility
Loring Byers Funeral DirectorsInc 21. Signature of Funeral Service Licensee 8728 Liberty Road, Randallstown, Md. 21133-4784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) **Physician** Cyte /Medical Due to (or as a consequence of) **Examiner** Constraintail Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? an cer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 XNo 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 25 No 2 1 npatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation s after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a To the Funeral D To the Hospitel 1156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical letely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mella m.O 0041410 1.3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEGINDER MEHTA Hastelik et sichertikert GINTEN MUS The supplies Tel 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 3 2004 Registrar

		,	1 For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artment of F	lealth and Death		Heg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Las Katherine S.	v) Pratt				2. Date of D	Day Y	3. Time of Death	
	/Media	cal	4a. Facility Name (If not institution, give		May	6, 200					
	Examir	ner	Quail Run Assisa		ilitu	4b. City, Town, o Bel A		iatri		arford	
-	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 H				
K	Director		216-05-7608	□M 2\(\sqrt{F}\) 89	Yrs.	Months Days	Hours M	sept.	12,1914 1	Birthplace (State or Foreign Country) Maryland	
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits	
	Manyl f sho	lo	Maryland Harford			allston				1 ☐ Yes 2 No	
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?	
	th with	aD	1800 Watervale F	Road			21047		u.s	.A.	
21215-0036	d within 72 hours after death with the Maryland Jiene Ir than "netural", or Itams 23a or 28e-f show Itta Medical Examiner roust be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:	i	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No		(Specify Yes or Nerto Rican, etc.)	o- 14. Race - Black, Specify:	American Indian, White, etc. White	
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of w	vorking	16b. Kind of Busin	ness/Industry	
121	within lene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			)		Auto Hau		
9	e filed withing the Hygiene. other there	e Co	12th Grade 17. Father's Name (First, Middle, Last)		П	omemaker	18. Mother's N	lame (First, Middle	Own Hor	ne	
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked oths other traumatic event,	To Be	Louis Slember	cker					Miller		
lan	2 sho and I s ma		19a. Informant's Name/Relationship (7						ber, City or Town, Sta		
	s 1 and 3 f Health Item 27 other tr		Mr. George Slembe			Waterval		Fallston			
Baltimore,	Pages nent of Hent of Hent tilte		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐			esition (Name of matory or other place			20c. Location - Cit		
Ħ	글본분급.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Lichn						k Funeral	e, Maryland	
Ba	Depa Impo any i		13. D.			9705 Bela	ir Rd.,	Baltimo	r Funerac re, MD 211	nomes 236	
	Physician		23a. Part 1. Enter the disease, or some shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.					arrest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		- 1	a	equence of):	reks i	DEMENT	14		Days	
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to for as a consu							
_	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	guence of):						
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687	tificate og phys as the	edlc		d				_			
O. Box	death cer e attendir ed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3 [	Ectopic pregnancy Other (specify)		23d. Date o Month	f delivery Day Year		
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Il Records,	The law ate has b page 2 si	Completed				,.		24a. Wa: auto perf 1 ☐ Yes	psy prior deal	e autopsy findings available r to completion of cause of th? Yes 2 \sum No	
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		104		eath (Check only	and the same of th	Assisted	
of	99 161	- To	1 Yes 2 No	1 Inpatient 2L	ER/Outpatien	t 3 DOA	4 Nursing	Home 5 Res	how injury occurred	Specify Living	
ion	ding After fune	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	(? Yes 2 □ No	200. Describe	now injury occurred		
Division	or Direction	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str ify)	eet, factory, office			(Street and Number own, State)	or Rural Route Number,	
	othe Hospital thin 24 hours a the Funarel I mpletely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time vestigation, in my op	e, date and placinion, death oc	ce, and due to the curred at the time	cause(s) and manne date and place, and	er as stated. due to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (N	fonth, Day, Year)	
7	١.		Dove:	()		D55.	306		MAY 7	2004	
	V		30. Name and address of person who o	completed cause of death (Ite	m 23a) (Type,	0 -	RD.	BALT	MORE	Wh 2/127	
> 3	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign		NIICE	~			ry didol	
	Registr	ar	MAY 1 3 2004	Liene	a pligh	vacas.					

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:00 a M g Reid May 2004 James /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Queen Anne Chestertown 203 Concord Road Chester Low..

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year)
Nov. 14, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2 F Maryland 73 218-26-2703 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County in than "naturel", or Itame 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Chestertown Md. Queen Anne 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number United States 21620 203 Concord Road permit. Pages 1 and 2 should be filed within 72 hours after death of Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itame 23s any injury or other fraumatic event, It a Medical Exaction mates. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years truck driver steel 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna Robinson George Reid, Sr. ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Concord Road, Chestertown, Md. 21620 Mildred Reid/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/2004 Bel Air Mem. Gdns. Bel Air, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Schimunek Funeral Home of Bel Air, Inc. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Hyelogerous le Komin **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) been signed by the s 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 □Unknown mahetis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by determined 4 - Homicide edical 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 29a. Certifie 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 123889 5/10/04 f death (Item 23a) (Type, Print) 223 1th & Street Mester town Wel 21620 vohal. ALROBAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sacks MAY 1 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 10:35PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 579-48-1363 Director JASHINGTON D.C Usual Residence of Decedent r 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 100 Director 10g. Citizen of What Country? ŏ Examiner must be 238 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite Armed Polices:
1 \_Yes 2 \_ No
If Yes, Give
Year or Dates: 1953-1955 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during dife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1,4or5+) ADMINISTRATIVE OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY E. ROBERTS #721 PUNTA GORDA, FL 33780 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burjal 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIFTS Reg. 5 \* 4 Donation 5 ☐ Other (Specify) 21. Signature of F Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prostate CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ŏ in the past 12 months? Month signed by the at d be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No peen 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has certificate of Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) P 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral dir 27. Manner of Death 1 Natural 2 Accident 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of Division 5 Pending investigation 1 🗌 Yes 2 🗆 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 39190 MAy 12,2004 and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH RILEY OLAND WOOD CT. SUITE !!! SILVER SPRINGS MD 20832 31. Date filed (Month, Day, Year)
MAY 1 3 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registra MPND ITFM #19a&b PER FH C831 5/13/04 THIF if icate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day JOHNNIE R. RICHARDSON /Medical MAY 10,2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN 1947, 1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 CAROLINA **Funeral** 220 30 6816 Months 1 XM 2 ☐ F 71 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location show 10d. Inside City Limits r than "naturel", or Itams 23a or 28a-f shov The Medical Examinations to motified at MD. NIA 1 X Yes 2 □ No BALTIMORE Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1638 N. BROADWAY U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XNever Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than 10TH LABORER JOHNS HOPKINS UNV other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JESSIE RICHARDSON ဂ ELIZABETH BATTLE DESCRIPTION OF THE PRINTS OF THE PRINTS 19830 in Albert Rout Avt. Numbrat Roam Dute 21/294. City or Town, State, Zip Code) (FRIEND) 2809 THE ALAMEDA BALTIMORE, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) Maus Claum Green Mountlem. May 14/2004 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME ature of Funeral Service Licensee 1412 E. PRESTON ST. BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac a respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physicien and the for use as the burial-transit the death certificate be executed 3 Due to (or as a onsequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) detached 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Kes 2 🗆 No 3 ☐ Probably 4 ☐Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform res 2 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 Yes 2 No Other: Certification: To 1 Inpatient 2 / R/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only e L 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who combleted caus 31. Date filed (Month, Day. 32. Registrar's Signature State Registrar 3 2004

Maryland 21215-0036

Baltimore,

Division of Vital Records,

			1 - For Amend Items 5,10e	Staten, com, vis/	13/04martm Certific	nent of F	lealth and Death		giene 001	+ 15380
	Physici	an	1. Decedent's Name (First, Middle, Last,		. , , , , , , , , , , , , , , , , , , ,		-	2. Date of Dea Month		3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give	RABOW street and number)	4b	City Town o	r Location of Dea	MAY	08 20 4c. County of D	
	Examir	ier	NORTHWEST H	105PITAL	R	ANDA	LLSTON	IN , MD		IMDRE
	Funeral		5. Social Security Number 6. Sec	TM OFF	Mor	nder 1 Year	If Under 24 Hr Hours Mir	1. (Month, Day	9.1	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	( 20,	58 Yrs.			DEC.1,	1945	RUSSIA
	the Maryland 28a-f show notified at		10a. State 10b. County	10c. Cit	y, Town or Location	)				10d. Inside City Limits
	the Maryla 28a-f shor	ctor	MD BALTII		REISTER	STOWN				1 □Yes 2 No
	with a or	Funeral Director	10e. Street and Number Glyndon Drive	e_#3		f. Zip Code	r I	1	10g. Citizen of What	,
	E 23	eral	109 GLYDON DRIVE	#3 - REISTER:	.S. 13. Was D	21136 ecedent of H	ispanic Origin? (	Specify Yes or No-	14. Race - A	U.S.A.
ဖွ		Fur	1 Never Married 2 💢 Married	Armed Forces? 1 ☐ Yes 2 🏹 No If Yes, Give	If Yes,	specify Cuba	an, Mexican, Pue	rto Rican, etc.)	Black, W	
5-0036	72 hours after "naturel", or ite	d by	3 Widowed 4 Divorced	Year or Dates:		es 2 No	Specify:		Specify:	WHITE
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212	giene. pr than	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	SOCIOLO	GIST			SOCIOLOG	Υ
	be filed within tal Hygiene. Id other than event, the Me	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, i	,	
Maryland	should by the marked marked imatic even	<sup>L</sup>	CONSTANTINE	Delay.	RABOW	(2)	ESPHII			KELSTEIN
Ma	is a		19a. Informant's Name/Relationship (Ty	NIFE					r, City or Town, State RSTOWN , M	
Je,			20a. Method of Disposition	20b. P	Place of Disposition semetery, crematory	(Name of		_	20c. Location - City	
altimore,	9 = 5		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	LINGTON C		· 1	/11/2004	BALTIM	ORE, MD
Balt	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service License						ON & BROS	
	ā. □ = 6 d		230 Part I Enter the disposed by some	inching a that accord the death						, MD 21208
, H			23a. Part1. Enter the disease or complishock, or heart ailure. List only or Immediate Cause (Final	ne cause on each line.		8			est,	Approximate Interval Between Onset and Death
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п	Examiner		Sequentially list conditions	)						
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):					
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	uence of):					
8760	cate be executed physician and the burial-transit	dlcal E		1.						
	rtificat ng ph) as th	Medi	IF FEMALE:							
Вох	that the death certifii ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	I death 3 □Ectop	ic pregnancy			23d. Date of o	delivery Day Year
P.O.	the de / the a ched f	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□ Pregnant at time of di 9□ Unknown	eath 5 🗌 Othe	r (specify)			Monar	Day rour
σ.	The law requires that the te has been signed by the sage 2 should be detached.	by Ph	Part II. Other significant conditions cor	ntributing to death but not resi	ulting in the underlyi	ng cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Records,	w require: been sig should be	ed b						1 □ Ye	es 2 🗆 No 3 🗀	Probably 4 Unknown
ecc	law requase been 2 should	Completed						24a. Was a		autopsy findings available o completion of cause of
	(Q LJL	Con						_ perform	ned? death	?
Vital	Physicien: The law this certificate has b ral director, page 2 s	o Be	25. Was case referred to medical examiner?	lospital: 🇝		Othi		ath Check on on		
of	Phy rthis ral d	J +	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun	+ □ Nursing i		ence 6 Other (Sp ow injury occurred	pecify)
ion	Attending I r death. actor: After by the funer	atio	1)XNatural 5 ☐ Pending investigation	(Month, Day Year)	Injury M	Work	c? Yes 2 □ No		. ,	
Division	or Atter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fa	ctory, office		28f. Location (St. City or Town	reet and Number or . n, State)	Rural Route Number,
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	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  1X Certifying Physical Examination (Check only one)	sician: To the best of my knoner: On the basis of examination and manner stated.	wiedge, death occur tion and/or investiga	rred at the tim tion, in my of	ie, date and plac pinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier	1 ()		29c. License	number	29	9d. Date signed (Mo	nth, Day, Year)
			* Wal	mlie	- MD	D	53910	)	MAY O	8,2004
	1		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	- Una	DIGA	PANISA	LLS TOWA	1
		10	A - MAHESHWAP  31. Date filed (Month, Day, Year)	/32. Registrar's Signa		MUS	FINE	, KHIVDA	LLSTOWN	, MD
	Sta Registr	-	MAY 1 3 2004	Dengue	J spa	us.				

State of Maryland / Department of Health and Mental Hygien 🛭 🕕 👢 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Ruth /Medical Sparks 2004 8:57a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3707 Loch Raven Blvd. Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. Director 104-32-4743 S.C. 4-22-39 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at X☐Yes 2☐No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2502 Montebello Terrace 21214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 17 No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: Black 3 ₩Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fund Raiser Legislative Aide 12th grade yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Baxter Bertha 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra <u>2005e.</u> Renee Sparks-Cuffie Daughter 1314 E. 33rd Street, Baltimore, Md. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Long Island Nat. Cem. 5/11/2004 Farmingdale, N.Y. Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Ave Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ca ll mo /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒️No To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sther (Specify) Sichers Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of Medical Certification: 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No death. filled in by the i 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
MAY 1 3 2004 201 6.0 Baltimor 21218 32. Registrar's signature State

Registrar

ROBERT STYERS 04-3179 DAP

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Unpend Item # 2 1 - State Registrar	3a <b>,27',28</b> 2-1'1	<b>Er nie G832</b> PG Cei	1/1/04 tas tificate of L	Death		Reg. No.	15382					
	Dhusisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of De	eath Day Yea	3. Time of Death					
1	Physici /Medio		Robe	ert Styers				MAY	11, 2004	4:05a M					
	Examir		4a. Facility Name (If not institution, give ATLANTIC GENERAL			4b. City, Town, or BERLIN	Location of De	ath	4c. County of D. WORCES'	eath					
	Funeral		Social Security Number     6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H		th 9. I	Birthplace (State or Foreign Country)					
	Director		204-52-4119	<b>X</b> M 2□ F	33 Yrs.	World Days	TIOUIS IN	APR 2,		nnsylvania					
,	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits					
	Mary I sh	ţō	PA York			Dover				1 ☐ Yes 2 XNo					
	th the	lrec	10e. Street and Number			10f. Zip Code		10g. Citizen of What	Country?						
	ath wi	ral	2001 Red Bank	Road, #1	.23	USA									
336	72 hours after death with the Maryland "naturel", or Items 23e or 28a-f show disal Exerts act must be realified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced		Was Decedent of Hi f Yes, specify Cubai 1 □ Yes 2X No		(Specify Yes or No arto Rican, etc.)		merican Indian, hite, etc. White						
9	2 hou	ted	15. Decedent's Ed	ucation	16a. Deced	ient's Usual Occupa	ation		16b. Kind of Busine	ss/Industry					
218		Completed	(Specify only highest gra	College (1-4or 5+	.)	kind of work done d OO NOT use retired;		rorking	Siding						
2	e filed within at Hygiene. other than 'vent, Itte Me		12		Sidí	ng Insta			Install	ation					
and		Be	17. Father's Name (First, Middle, Last) UNK •						, Maiden Sumame)	173717					
Ž	should be ind Mental I marked o	ို	19a. Informant's Name/Relationship (7	voe Print)	19h Mailin	n Address /Street a	Judy		er, City or Town, State	UNK.					
Z	d 2 in all		Tammy R. Styers			Red Bank				315					
re,	of Heall item 2		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location - City						
E	Pages nent of int: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Metro Cre		1	13-04	Baltim	ore, MD					
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Liegh Edward A. Gr	gorchik	C <sup>22</sup>	. Name and Addres	s of Facility SOC1e	tv of M	D. Inc.						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Appropriately:												
	Physician		Immediate Cause (Final disease or condition	Read Injur						Onset and Death					
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):										
ı	LAdiminei	-	Sequentially list conditions, if any, leading to immediate	b. — Due to (es se s	consequence of):										
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<u>,</u>	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):										
68760,	rtificate be executed ng physician and s as the burial-transit		· ·	d											
	rtifical ng phy as th	Medical	IE EENALE.												
O. Box	death ce e attendi sd for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of o Month	23d. Date of delivery  Month Day Year						
S, P	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions co	entributing to death but	not resulting in the ur	iderlying cause give	n in Part I.	23e. Did to	obacco use contribute	to the cause of death?					
rds	w require been sig should b							101	res 2 No 3	Probably 4 Unknown					
Record	law as b 2 sl	Completed						24a. Was	osy prior to	autopsy findings available completion of cause of					
al F	ician: The certificate his rector, page								rmed? death' 2 □ No 1 ☑ 🔾						
Vital		Be c	25. Was case referred to medical examiner?  1 X Yes 2 □ No	Hospital:	Visor	Other		eath Check onl o							
of		To To	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)		28c. Injury Work	4   Nursing		dence 6 Other (Sp	pecify)					
ion	Attending Ir death. ector: After by the funer	atlor	1 □ Natural 5 □ Pending 2 🗓 Accident investigation	may 11, 200		A M 1 □ Y			11 From Balo	COV					
Division	r Attener deatler dector:	Certification;	3 Suicide 6 Could not be determined		y - At home, farm, stre (Specify)	et, factory, office				Rural Route Number, h Street, Ocean					
	spital or nours afte nerel Dir	Cer		Other Resi	dence			City, Md	, clare, 17 70L	i birect, ocean					
	5 4 11 49	edical	29a. Certifier (Check only one)  1☐ Certifying Phy 2☑ Medical Exam	vsician: To the best of iner: On the basis of e and manner state	xamination and/or inv	occurred at the time estigation, in my opi	e, date and place inion, death occ	ce, and due to the courred at the time, of	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)					
	To the within 2. To the I complete	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (Mor						
			1 Quest			OCM	1E 		MAY 11,	2004					
				310, MD	111		reet, Ba	altimore,	Maryland	21201					
	Sta Registr	1.0	31. Date filed (Month, Day, Year)  MAY 1 3 200	A. Registrar	s Signature	SE .									

State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #31 per dvr g831 5/13/04 Contificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 11,2004 Year **Physician** JESSIE STEWART 9:00 A M /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) **Examiner** 502 N. LINWOOD AVE. BALTIMORE
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F 4, 244 30 5938 85 Yrs. 1918 S. CÁROLINA Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Exeminar maint by notified at 1, Yes 2 No Director MD. N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 502 N. LINWOOD AVE. 21205 U.S.A Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Marned 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 XWidowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE CITY buld be filed within Mental Hygiene. Elementary/Secondary (0-12) 6TH College (1-4or 5+) SCHOOL CAFETERIA COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events. WILLIAM BROWN SARAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 502 N. LINWOOD AVE. BALTIMORE, MARYLAND 21205 NORMA WALLER (NIECE) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE CEMETERY MAY 18, 2004 BALTIMORE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME BALTO, MD 1412 E. PRESTON STREET 21213 Part 1. Enter the disease, or complications that caused the lear. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4theroscientic Commary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to we as a consequence of) Examiner Hy Albertolesterolemico.

Due por ras a consequence of): law requires that the death certificate be executed burial-transil and Box 68760. physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? for 4☐Pregnant at time of death 5 Other (specify) Yes 2 L No signed by the a d be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 1 Yes 2 PNo 3 Probably 4 Unknown 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? eged 1 Yes 2 HO certificate 1 Yes 2 PNo Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 THE 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral dir this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Attending Division 1 Natural 2 Accident Injury 5 Pending within 24 hours are: were To the Funeral Director: At 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signatur, and tipe of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) orlean St; Baltimore MD 21224 32 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2004 Registrar

04 - 3139Unpend Item#23a-b,27,PFR MF,C831,5/27/Oveg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S MICHAEL J. SWADER Amend Item 23a-b, States of Maryland & Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 **Physician** Year 9, Michael James Swader MAY 0845 АМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 214 ULLMAN ROAD ANNE ARUNDEL **PASADENA** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year) | August 30,1968 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F 35 Yrs. 218 78 7222 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28e-f ebor other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Maryland Anne Arundel Pasadena Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 214 Ullman Road 21122 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "naturel", or lier 1 Never Married 2 Married altimore, Marvland 21215-0036 1 Yes 2X No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Audio / Stereo Self employed 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gordie Swader Gladys Horn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Kelly Swader / Wife 214 Ullman Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 (ment of t 1 

Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Important: If any injury or once. Glen Haven Mem. Park 5/14/2004 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 pramueauti 23a part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurer List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardine Archythmia Methadone intoxication /Medical Due to (or as a consequence of) Examiner Myccardial Hypertrophy Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) , the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? es 2 No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) AT SCENE 1 X Yes 2 🗌 No this neral Director: After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Whatural 5 Pending investigation 5-9-04 1 Tes Unknown 2 Accident 6 Could not be determined 3 TSuicide 28f. Location (Street and Number of Rural Route Number, City or Town, State) 214 Ullman Rd., 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Pasadena, MD Home 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 2 To the 29d. Date signed (Month, Day, Year MAY 10, 2004 29b. Signatu ertifie 29c. License number

State Registrar

of death (Item 23a) (Type, Print)

32. Registrar's Signature

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dona 1d Sr. Scharf May 11 2004 8:50 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 103 Woods Avenue Ferndale Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/9/1934 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 70 213-32-0960 Director Tndiana Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or flems 23a or 28a-f show interment be notified at MD Anne Arundel Director Ferndale 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 103 Woods Ave. USA death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iten any injury or other treumatic event, Ite Medical Exercipiest once. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland Refrigeration Elementary/Secondary (0-12) 12 College (1-4or 5+) Air Conditioning & Refrigeration 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Fred Scharf Lillian Ziemer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Gloria June Scharf/wife 103 Woods Ave., Ferndale, MD 21061 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Cremation | 5/11/2004 | Stevensville, MD 4(□Donation 5 Ø Other (Specify) 22. Name and Address of Facility Singleton Funeral Home 21. Sig sture of Funer Service Livensee M01364 1 Second Ave SW Glen Burnie MD 21061 14 1 Km 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 14 Months /Medical Due to (or as a winsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ■Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Division of Vital 1 ☐ Yes 2 ☐ No 1 Yes 2 **U**No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Desidence 6 Other (Specify) ို 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) narkons M.D D39505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yndhish markan 305 Hospital Drive, Glen Burnie, MD. 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAY 10, **Physician** 2004 SARAH ELTZABETH TREASTER 6:45P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MARINER HEALTH **OVERLEA** BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

81 Yrs. Months Days Hours Min. 5. Social Security Number 191–18–9586 8. Date of Birth (Month, Day, Year) 12/13/1922 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Director PA. Usual Residence of Decedent the Maryland Baltimore 10c. City, Town or Location Rosedale 10a. State MD 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? death with 8033 Edgewater Ave. 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or flar any injury or other traumatic auch. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2000 White ģ 3₺ Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Social Security Admin. Elementary/Secondary (0-12) College (1-4or 5+) Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Hostetler Zeda McCloy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Treaster SON 8033 Edgewater Avenue Rosedale Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Oaklawn Cemetery 5/14/04 Baltimore Md \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ke of Funeral Service Licensee Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0F 3L ANCINOMA MONIN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Day Year 5 Cher (specify) the Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy page performed? certificate Division of Vital 2 100 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 →No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) クリフタムら L004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 ALITEM mes TOWNEW UND 31. Date filed (Mo 32. Registrar's Signature State Registrar

Amend Item 16b per FH, 631,05/13/44mp Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician MAY **TABERSHAW** 10, 2004 HAROLD 5:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1 M 2□F **Director** 248-44-4739 80 AUG.5,1923 NY Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Maritical Exampling as published at once. Director 1 ☐ Yes 2 ☑ No MD BALTIMORE OWINGS MILLS 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9005 GROFFS MILL DRIVE 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 🛣 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OPTOMOLOGIST Optometrist MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS **TABERSHAW** ပ GOLD TE POSNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARENE TABERSHAW / WIFE 9005 GROFFS MILL DRIVE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place)

PARK 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State OHEB SHALOM MEMORIAL 5/11/2004 4 Donation 5 ☐ Other (Specify) REISTERSTOWN, MD o Juneral Service License e 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Therosclerotive Vascular diease disease or condition resulting in death) Tears /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter onderlying Cause (Disease or injury the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medlcal use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? 20 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending within 24 hours after deam.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No hours after death. investigation M 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35844 2004 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5400 MD Count Koggen Old 21133 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 3 2004 Registrar

		For State Registrar	State of	Maryland	/ Depa	artment of	Health an	d Mental H	ygiene 2 (	004 15388	
Physicia /Medic Examino	al	Decedent's Name (First, Middle,     PHYLLIS A. THOMAS     4a. Facility Name (If not institution,		ber)		4b. City, Town,	or Location of D	2. Date of I Month Man	Death Day	Year 2004 3. Time of Death 0620 M	
Funeral Director		UMMS DEATON  5. Social Security Number  212.50.5594	5. Sex 7	7. Age (In yrs. las	s <i>t birthday)</i> Yrs.	BALT I MOI If Under 1 Yea Months Days	r If Under 24	Hrs. 8. Date of E (Month, I		9. Birthplace (State or Foreign Country)  MD	
ith the Maryland or 28a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City,	Town or Lo	cation		100.00		10d. Inside City Limits 1  Yes 2 No	
death w	Funeral Director	10e. Street and Number  601 SOUTH CHARLES  11. Marital Status  1 ☑ Never Married 2 ☐ Marrier	12. Was Deced Armed Force	lent Ever in U.S.		10f. Zip Code  21230  Vas Decedent of Yes, specify Cu	Hispanic Origin ban, Mexican, P	USA No- 14. Rad	f What Country?  ace - American Indian, ack, White, etc.		
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yland 21 ould be filed w I Mental Hygier Parked other it	To Be Cor	12 17. Father's Name (First, Middle, La CAREY N. THOMAS				SABLED	SHIRI	Name (First, Middle	S	ne)	
Ore, Mar ges 1 and 2 sh t of Health and If item 27 ism or other traum		19a. Informant's Name/Relationship  CHRISTOPHER L. THOM  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3	IAS S	ON 20b. Plac	2001 W		E. BALTIM	Rural Route Num IORE MD 21: Date	230	State, Zip Code)  City or Town, State	
Baltimore, I permit. Pages 1 and Department of Healti Important. If item 2, any injury or other 1 once.		4 Donation 5 Other (Spe 21. Sign Was Funeral Service Lic	cify)		22. F1!	EMATORY, IN  Name and Addr  NK FUNERAL  6 CRAIN HW	ess of Facility . HOME, P.	A. BURNIE, M		E, MD	
Physician /Medical Examiner	<u>.</u>	23a. Pakt 1. Enter the disease, of commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Con Due to (or Alha	ard fac as a consequer as a consequer	an nce of): ohc	the mode of dy  Thomas  Hoom	25		arrest,	Approximate Interval Between Onset and Death	
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, P.O. Box 68 that the death certifical led by the attending phediached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outco 1 □ Live birth 4 □ Pregnan 9 □ Unknow		23d. Date Mor	e of delivery nth Day Year					
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he Hospi n 24 hou he Funei pletely fill	edical	one)	Physician: To the be aminer: On the basis and manner	s of examination	dge, death and/or inve	stigation, in my	opinion, death or	ace, and due to the courred at the time,	cause(s) and mar date and place, a	nner as stated. Ind due to the cause(s)	
To see the see of the		29b. Signature and title of certifier  30. Name and address of person wh	o completed cause of	of death (Item 23	la) (Tvna P		304014		5/7/0		
State Registra	е		Tiensity St 22. Regi	istrar's Signature		pu-l c	ial sout	nchale	ask Ba	Ihmane MOXK30	

		1 - For State Registrar	State of Maryland	/ Depa	rtment of l	lealth and Death	Mental Hy	ygien 🛭 🕦	04	15389
		Decedent's Name (First, Middle, Land)	ast)				2. Date of D			3. Time of Death
Physic /Med		CAROLYN			Wil	LSON	Month MAY	8 , 200	Year	5:00
Exam		4a. Facility Name (If not institution, gi	ve street and number)	or Location of De	ath		4c. County of Death			
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Funera			Sex 7. Age (In yrs. las 1 ☐ M 25☐ F		If Under 1 Year Months Days			irth lay, Year)	9. Birth	place (State or Foreig
Directo		219-70-2738 Usual Residence of Decedent	46	Yrs.			4-10		Md	•
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death with the Maryland ms 23a or 28a-f ehow rmust be notified at	ţ	Md. NA	D	- 7 <del>-</del>						1 XYes 2 □ N
r 28a	rec	10e. Street and Number	Do	altimo	10f. Zip Code			10g. Citizen of	What Cou	ntry?
h witi	ai D	1809 St. Paul S	treet		2120	)2		US		
Baitimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event. Ite Naulsal Examinar must be notified at	Funerai Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H	lispanic Origin? (	Specify Yes or N	o- 14. Ra	ce - Ameri	can Indian,
after or ite	E	1 Never Married 2 Married	1 ☐ Yes 2♥ No If Yes, Give		Yes, specify Cubi		rto Hican, etc.)		ck, White,	etc.
5-0036 72 hours aft natural, or	d by	3 Widowed 4 Divorced	Year or Dates:	_   '	∐Yes 2∏XNo	Specify:		Specif	<sup>fy:</sup> B	lack
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and the find he had he had he had of	Be						ame (First, Middle	a, Maiden Sumar	πθ)	
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Man d 2 sl th an 7 is r							Rural Route Numb		State, Zip	Code)
Heall Heall em 2		Jane Bostic  20a. Method of Disposition	Mother 20h Plac		14 St. Pa ition (Name of	aul St.,	Baltimo			202
Definition of the pages 1 a Department of Heal mportant: If item any njury or otherwise.		1 Burial ZCremation 3	Removal from State cem	etery, crem	atory or other plac	· 1		20c. Location	- City or To	own, State
it. P. rtme rtani		' 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	GLE		nt Cem.		7–04	Baltin	ore,	Md.
Depermine Deperm	, ,	21. Signature of Puneral Service Lice	Warre		Name and Addre	•	Balt:	imore, M	id.	21202
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Examiner			Due to (or as a consequen							id
	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen		openia				- 1	one week
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w requires been sisted to should be	iete						24a. Was	an 24h V	Noro autor	osy findings available
The lav	Completed						autor	osy p	prior to con	npletion of cause of
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	OB	examiner?	Hospital:	(Outrotion)	aC DOA Othe		ath Check only o			
	H- 4	27. Manner of Death	28a. Date of Injury 28	Outpatient b. Time of	3 DOA	4 ∐ Nursing ł	Home 5 Resident	dence 6 ∐Othe how injury occurr		")
l or Attending I after death. Director: After I in by the funer	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work	<br Yes 2.□No				
I or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not b	286. Place of Injury - At nome	, farm, stree	t, factory, office		28f. Location (S	Street and Numb	er or Rurai	Route Number.
al or A	ert	4  Homicide determined	building, etc. (Specify)				City or Tov	vn, State)		
To the Hospitel of within 24 hours are to the Funeral Discompletely filled it	edicai C	29a. Certifier (Check only one)	ysician: To the best of my knowled hiner: On the basis of examination	dge, death o and/or inve	occurred at the time stigation, in my op	e, date and place pinion, death occi	e, and due to the	cause(s) and ma date and place, a	nner as sta	ated. the cause(s)
To the Hos within 24 h To the Fur completely	Mec	29b. Signature and tiple of certifier	and manner stated.		29c. License					
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1)		30. Name and address of person who			,	FF C				2.0-
		DOCTOR ANAND PARENH, 1			ANIH MC	FLE STREE	, BALLIMO	LE , MAI-YL	MND, 21	487
Sta Regist		31. Date filed (Month, Day, Year) MAY 1 3 2004	32. Registrar's Signature	Se	rocks					

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death WEBB **Physician** Year 4 EAGAN MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMIRE MANDALISTONN NORTHWEST If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Hours Yrs Director 244-16-1158 Jan 16 1921 NC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Madical Examinations by retified at 10d. Inside City Limits Md Carroll Svkesville Director 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6317 Georgetown Blvd Apt E 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural, or Item any injury or other traumatic event, Ite Madical Exami 1 Yes 2 No WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Ā Specify: Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) transportation truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Albert Webb Asalie (maiden name unknown) 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renna Barbara Webb Spiva 7406 Second Ave., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Md All County Cremation | 5-13-04 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Paige Haight trudue P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2 No 200No 1 Yes 1 Tes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 1 Tes 2 No Hospital: Other: 2 1 Propatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Certification: 5 Pending investigation aturat 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NHC MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 3:10am <sup>™</sup> May 1,2004 Webb Bernard /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Mariner Health of Greater Laurel Laurel | Honder 1 Year | Hours | Min. | Month, Day, March 18, Birthplece (State or Foreign Country)
 VA 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** 1**X**M 2□F 85 231-015451 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rithan "natural", or itama 23a or 28a-f show the Medical Examiner trust be collined at Laurel MD Prince Georges 1 Tyes 2XXNo Be Completed by Funeral Director 10g. Cilizen of Whal Country? 10f. Zip Code 10e. Street and Number with 1 14800 Fourth Street, 43 B 20707 USA death v 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Unk. 1 Xes 2 No If Yes, Give 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturat, or its ury or other traumatic svant, the Medical Exertion. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 XNO Specify 3€Widowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 9 0 Office Clerk Coast Guard 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Webb, Jr. Bessie Durham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29504 Bernard Webb, Jr./Grandchild 244 West 29th Street, Norfolk VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or ance. Parker Cemetery May 6, 2004 Rocky Mount, 4 ☐ DonAtion 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee Thomas P. Zizos 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Ave. Baltimore Md. 21230 23a. Pert1. Enter the disase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition **Physician** 5 years Cancer of Prostate with Metastases resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day Year Month detached for 4 Pregnant at lime of death 5 Other (specify) □Yes 2□No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Cirhosis of Liver 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 Yes 2 No 1 Tyes Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo B 2 Division of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident after death

Director: / 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier. May 2,2004 D24721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadut 14333 Laurel Bowie Rd. Laurel Md. 20708 22. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 1 3 2004 State outs Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 🎧 📙 15392 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Yeer Adrienne 9:00 M 0 /Medical 2000 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1 stiged 96 Bay H NIA 7. Age (In yrs. last birthday, If Under 24 Hrs. 6. Sex 5. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 ☐ M 2 🖸 F 423-94-9314 94 Director 18, 1910 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Maxical Examinar must be notified at Maryland N/A Baltimore Directo 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Edgevale Rd. 21210 Funerai United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ii. Pages 1 and 2 should be filed within 72 hours after inment of Health and Mental Hygiene. intant: If item 27 is marked other then "natural", or Ite 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3XWidowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Wilson Adrienne Gibson Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bruce Webb/daughter 105 Edgevale Rd. Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9 `4 ☐ Donation 5 ☐ Other (Specify) Knights of Pythias May 13, 2004 Russellville, Alabama permit.
Deporte
Importe
any nju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Priysician disease or condition resulting in death) 0 Je ( /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence burial-transit death certificate be exec Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 menths? 1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe c by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate has page 2 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ es 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending thours after death.

uneral Director: After a filled in by the fun 5/3/04 investigation 6 1 ☐ Yes 2 No tell off Bod 3 Suicide 6 Could not be 281. Location (Street and Number of Rural Route Tumber, City or Town, State) 105 Edge Vale (Cod) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined within 24 hours a To the Funeral C tone NG. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address.

nother

MAY 1 3 2004

31. Date filed (Month, Day, Year)

oleted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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			1- State Registrar	•	artment of Health and Martificate of Death	lental Hygier	/ 11114	15393			
	Physici /Medic		Decedent's Name (First, Middle, Last)  Henry	Lee	Ward	2. Oate of Death Month	Day Year	3. Time of Death  3: COPM			
	Examin	er	4a. Facility Name (If not institution, give street and SINAM HOSPITAL OF	MALTIMORE	4b. City, Town, or Location of Death BALTIHORE CI	ry	4c. County of Dea	th			
	Funeral Director		5. Social Security Number 6. Sex XIXM 2	7. Age (In yrs. last birthday) F 64 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 02 07	9. Bir 40	thplace (State or Foreign ountry) NC			
	sryland show		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits 1 ★ Yes 2 □ No			
	th the Ma or 28a-f	Director	MD NA 10e. Street and Number	Baltimo	10f. Zip Code	10g. 0	Citizen of What Co				
	s 23a	ral	5022 Queensberry A		21215	noify Von or No	U.S.A.	nican Indian			
336	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel; or Items 23a or 28a-f show ant, the Macincel Exploiter must be notified at	by Funeral	Ame  1 Never Married 2 Married 1 Yes	es 21 No	Was Decedent of Hispanic Origin? (Spo If Yes, specify Cuban, Mexican, Puerto 1☐ Yes 2☐XNo Specify:	Rican, etc.)	Black, Whit				
21215-0036	be filed within 72 hours aft ital Hygiene. It other than "naturel", or event, It's Medical Exam	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12)  Colle	ted) 16a. Dece (Give life. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business	Vindustry			
	filed withir Hygiene. other than rent, the M		8th grade na 17. Father's Name (First, Middle, Last)		Disabled  18 Mother's Name	(First, Middle, Maide	Disab	led			
Maryland	be d la l	To Be	Walter Beamon			lae Thomp	,				
Mar	7		19a. Informant's Name/Relationship (Type, Print)  Bettie L. Ward-Wife		ng Address (Street and Number or Rura Queensberry Av						
ore,	t. Page rtment o rtent: if njury or		20a. Method of Disposition    Burial 2   Cremation 3   Removal f	20b. Place of Dispo cemetery, crer	esition (Name of natory or other place)	Date 20c.	Location - City or	Town, State			
Baltimore,		Į	*4 □ Donation 5 □ Other (Specify)  21. Signature of Fundary ervice Licensee	King Me	morial Park 5/1 2. Name and Address of Facility arch F/H West	.3/04 Ra	ındalls	town, Md			
ä	permi Depa impo any ii		23a. Part1. Ent. the disease, or complications to			Baltimo	ore Md	21215			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	olon Can		or respiratory arrest,		Approximate Interval Between Onset and Death			
	Examiner		Sequentially list conditions b.	e to (or as a consequence of):				•			
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c								
8760,	cate be executed bhysicien and the burial-transit	Tesulting in death) Last Due to (or as a consequence of):  d.									
9	ertificating physes as the	Medi	IF FEMALE:								
O. Box	he death certific the attending p ched for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year			
Q.,	The taw requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	ed by Ph	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco		o the cause of death?			
Records,	The taw recate has bee page 2 sho	Completed				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of			
Vital	Physicien: The this certificate har ral director, page	Be	25. Was case referred to medical examiner?		Othor	(Check only one)					
of	ding Phys J. After this of funeral dir	lon; To	27. Manner of Death  Natural 5 Pending	1 M Inpatient 2 ☐ ER/Outpatier Date of Injury Month, Day Year) 28b. Time of Injury	it 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how in		ocify)			
Division	or Attendition death Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At home, farm, str building, etc. (Specify)		281. Location (Street City or Town, Sta		ural Route Number,			
_	To the Hospital within 24 hours a To the Funeral completely filled	edical C	(Check only 2 Medical Examiner: On t		h occurred at the time, date and place, vestigation, in my opinion, death occurr						
	To the within To the Comple	Me	29b. Signature and title of certifier		29c. License number		Date signed (Mont				
	Q		30. Name an address of person who completed	cause of death (Item 23a) (Type,	RES-600 Print) JEST BELVEBERE A	FE BALFIN	10RE H	D 21215			
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	routh						

DHMH 17 Rev 1/2001

WARD, HENRY C

			1 - For State Registrar	State	of Maryla	and / Depa <i>Cel</i>	artment of rtificate of	Health and Death	d Mental Hy	rgiene 20	04	15394
			1. Decedent's Name (First, Middle	e, Last)					2. Date of De	aath Day	Year	3. Time of Death
	Physicia /Medic		Robert Lee	Allen					April	26, 200		5:34am M
7	Examin		4a. Facility Name (If not institution	, give street and n	um <i>ber)</i>			or Location of De	eath	4c. County	of Deeth	
			4701 Plata St.				Clinto			Prince		
	Funeral		5. Social Security Number	6. Sex 1 M 2 ☐ F		rs. last birthday)	If Under 1 Yea Months Days		in. (Month, Da	ay, Year)		lace (State or Foreign
*	Director		239-70-5989			60 Yrs.			Jan. 22	2, 1944	Nort	h Carolina
	and *		Usual Residence of Decedent  10a, State 10b, County		10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	Aaryl F sho	ō	Maryland Prince	e George	C1.	inton						1 Yes 2 □ No
	28a-	Directo	10e. Street and Number	: George	CI.	LIILOII	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	With Ba or	ō	4701 Plata	Street			20735			United	Stat	es
	hours after death with the Maryland tural; or Hema 23a or 28a-f show a Examiner navit be modified at	Funeral	11. Marital Status	12. Was De	cedent Ever in	ı U.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No	o- 14. Race	e - Americ	an Indian,
0	or from		1 Never Married 2 Mar	ned 1 X Yes	2 No	+	ryes, speciny Cu 1 □ Yes 2 🛛 No	ban, Mexican, Pu o <i>Specit</i> v:	erro Hican, etc.)		k, White,	
ğ	ral', c	l by	3 Widowed 4 Divorced	If Yes, G Year or	Dates:	1983	TO THE ZIN	зреспу.		Specify	:Blac	: K.
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Maryland 21215-0036	d 2 should be th and Menta 7 is marked traumatic ev	၉	19a, Informant's Name/Relations			10h Mailir	a Address (Street		Rural Route Numb		State Zin	Code
Σ Σ	12 nar		Camilla Allen	/ Wife			-		Clinton,	-	-	
a,	s 1 and 2 if Health item 27 other tr		20a. Method of Disposition		201	. Place of Dispo	sition (Name of		Date	20c. Location -		<del></del>
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,	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on		٠ ٠٠ - ١٠	. 0:-	-1-+			_	Interval Between Onset and Death
į.	/Medical		disease or condition resulting in death)	aDue to	o (or as a cons	sequence of):	c pro	5161	re co	an cor		e 2 geor
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9 ×	ding F	/Me	IF FEMALE:	220 Huge o	utcome of pre-	ananov		<u> </u>				
Box	eath certifi attending   I for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 F	etal death 3	Ectopic pregnan	су		23d. Date Mor	e of delive oth	ry Day Year
o.	the s	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unk	gnant at time o nown	ordeath 5	Other (specify)					
0_	The law requires that the de ite has been signed by the a page 2 should be detached i	Ph.	Part II. Other significant condition	ons contributing to	death but not a	resulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use contr	ibute to th	e cause of death?
Records,	uires sign d be	d by							10	Yes 2 No	3 🗌 Prob	ably 4 Unknown
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He He	ne lav s has ge 2	ф							- auto	psy p ormed? d	rior to cor eath?	npletion of cause of
Vital		e C	25. Was case referred to medica					26 Blace of D	1 Tyes Death (Check only of		Yes	2∐ No
	Physician: The lav this certificate has al director, page 2	To B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3 DOA O	thor	Home 5 X Resi		r (Specifi	4)
ō	9 Phy er the		27. Manner of Death	28a. Date	e of Injury	28b. Time of	28c. Inji	ury at		how injury occurre		,
<u>o</u>	ath. r: Afte e fun	atio	1 Natural 5 Pendir 2 Accident investi	9	onth, Day Year,	) Injury		ork? ]Yes 2∐No				
Division of	or Attending Patter death. I Director: After to in by the funera	iffic	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Plac	ce of Injury - A		eet, factory, office	)	28f. Location ( City or To	Street and Number	er or Rura	l Route Number,
	tal or A	Certification:			amy, oto. (ope				0.0, 0.70			
	houn uner uner	edical	29a. Certifier 1 Certifyir	ng Physician: To the Examiner: On the	ne best of my l	mowiedge, death	occurred at the	time, date and pla	ice, and due to the	cause(s) and mar	nner as st	ated. the cause(s)
	To the Hospital or Attending Physician: within 24 hours atter death within 22 hours atter death of To the Fundral Directors this completely filled in by the funeral director, completely filled in by the funeral director,	Medi	one)	and ma	nner stated.			nse number	1	29d. Date signed		
-	To To		29b. Signature and title of certifie	00		A A 5	290. Licer	So transpar	myland	11 I	O \ =	Day, real)
2 /	2111		- Turky	<u> </u>	LONG CO	~ [V]	) D	00315	086	TIO	0 3	1004
4	8)110		30. Name and address of person	who completed car				DOY A	DAW		WD	2-11-1-
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sig	gnature )	na		, Coree	mn	ナー	SCHTIMA
	Registr		APR 2 9 200		N be	A.z. M				1110	1	0

			1 = For State Registrar	State of M	arylar	nd / Depa <i>Cei</i>	artme rtifica	nt of H	lealth ai Death	nd Me		iene 2	004	15395	
			1. Decedent's Name (First, Middle, L	ast)						2	2. Date of Dea	th		3. Time of Death	
	Physici /Medi		Grace Violet A	shbv						A.	Month pril	21,	2004	10:21pM	
•	Examir		4a. Fecility Name (If not institution, g.				4b. Ci	y, Town, o	r Location of	Death		4c. County of Death			
			Bradford Oaks N					inton					nce Ge		
	Funeral		7 7 7	Sex 7. Ag		last birthday) Yrs.		er 1 Year s Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day	Year)		place (State or Foreign ntry)	
	Director		182-12-2858 Usuat Residence of Decedent		81	713.				I N	Nov. 28	, 1922	Penn	sylvania	
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits	
	Mar.	ģ	Maryland Charles	3	W	aldorf								1∭ Yes 2 No	
	or 28	Director	10e. Street and Number				10f. 2	ip Code			1	0g. Citizen o	f What Cour	ntry?	
	23a		307 Bucknell Circ	:le				206	02			U.S.A	. •		
	ar des	nne	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Nas Dec	edent of H ecify Cuba	ispanic Origi In, Mexican, I	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		ace - Americ lack, White,		
36	filed within 72 hours after death with the Maryland Hygiene yther than "naturel", or Itams 23a or 28a-f ehow with the Medical Examinar must be routiled at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🎛 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 I If Yes, Give Year or Dates:	No		1 🗆 Yeş	2 <b>X</b> No	Specify:			Spec	city: T.Th.	ita	
8	ture ture	edt	15. Decedent's I			16a. Deced	ient's Us	ual Occun	ation			16b. Kind of		ite	
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2	d with	mo:	12	College (1-40)	,+,	Cler	ica1					Sarah	Bucha	anan	
2	al Hy d oth	Be (	17. Father's Name (First, Middle, Las	t)					18. Mother's	's Name (i	First, Middle, I	Maiden Suma	ame)		
<u>X</u>	Ment Ment arke	ပ္	Frank Seitz								chanan				
Maryland 21215-0036	and and is m	1 4	19a. Informant's Name/Relationship								Route Number				
	1 and Health Pm 27 thar t		Charles L. Ashby	', 111 - So		307			Circle	e, Wa	ldorf,				
و	T Hite		1 X Burial 2 ☐ Cremation 3		0	emetery, cren	natory o	other plac				20c. Location			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f ehow arry injury or other traumatic event, the Medical Examinar must be notified at ance.		* 4 □ Donation 5 □ Other (Spec 21. Signature of Europeal Service Mcc		FO	rt Linc			ss of Facility					Maryland	
Ba	Depril Important		V/Junter	1015	317=	>				Vas	ch's Fu Hyatts				
	<b>1</b> 2		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the deat								, 110 2	Approximate Interval Between	
}	Physician		Immediate Cause (Final disease or condition	Atheros		otic Ca	ardi	ovasc	ular D	Disea	se			Onset and Death Years	
	/Medical Examiner		resulting in death)	Due to (or as	-										
	Examine:	<u>.</u>	Sequentially list conditions,	b											
	pet ist	nlne	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence or).									
	axecu al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):									
8/60,	death certificate be executed attending physician and of for use as the burial-transit	dical		. d.											
9	tificat ng phy as th	60													
Rox	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic	pregnancy					ate of delive	•	
0	the at	slci	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4☐Pregnant at 9☐Unknown	time of d		Other (					~	lonth	Day Year	
٦.	res that the de signed by the a I be detached f	Phy	Part II. Other significant conditions	contributing to death b					on in Bart I		23a Did tob	2000 USO 000	atabuta ta th	e cause of death?	
Kecords,	The law requires that the tensor bear signed by the base been signed by the bage 2 should be detache	d by	Takin on on one	osimbuling to double b	at 110t 103	and g in the a	ideriyirig	cause give	on in Fait i.					ably 4 []Unknown	
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Vital	(G L-L	e C	25. Was case referred to medical						26 Place of	d Dooth (	1 ☐ Yes 2	X No	1 🗌 Yes	2 🗆 No	
	ysician: is certific director,	o B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatien	3 🗆 0	OA Othe			Check on one 5 ☐ Reside		har (Specif	d	
0	g Physie this neral di	T:U	27. Manner of Death	28a. Date of Injui (Month, Day		28b. Time of		28c. Injury Work			d. Describe ho				
Ö	ttending I death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation	n	roar,	Injury	М		r Yes 2∐No	o					
DIVISION OF	l or Attendater deatl Diractor:	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ry · At ho . (Specif)	ome, farm, stre	et, facto	ry, office		28f	Location (Str City or Town	eet and Num State)	ber or Rural	Route Number,	
	urs after or real Di														
	o the Hospitel or Attending Physician: Ithin 24 hours after death.  o the Funaral Director: After this certific ompletely filled in by the funeral director.	Medical	29a. Certifier 1	miner: On the basis of	examina	wledge, death tion and/or inv	occurre estigation	d at the tim n, in my op	e, date and p pinion, death	place, and occurred	d due to the ca at the time, da	use(s) and m te and place	anner as sta , and due to	ated. the cause(s)	
	To the Hospite within 24 hours To the Funaral completely filled	Me	29b. Signature and title of certifier	and manner sta			2	c. License	number		29	d. Date sign	ed (Month, E	Day, Year)	
A	- 5 - 5		) //	H				1943				April			
	(5		30. Name and address of person and	completed cause of de	eath (Item	1 23a) (Type. I						-11	, -		
	36		. ( //	.D. 11701	Livi	ingston		ad, #:	103, F	ort V	Washing	ton, N	1D 207	44	
	Sta		31. Profiled (Month; Pay Year)	32. Registra	r's Sio a	ture									
6.	Registr	517			-										

State of Maryland / Department of Health and Mental Hygiene? [] [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** APRIL 2004 WILLIAM ADAMS 20 2315 ALBERT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 🛣 M 2 🗆 F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 81 Yrs. 218-14-4179 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo DELAWARE SUSSEX SELBYVILLE 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code ō or items 23a 23F LAWS POINT ROAD 19975 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: \$ WHITE 3 ☐ Widowed 4 ☐ Divorced netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SPRINKLER FITTER PIPE FITTER 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Importent; if tiem 27 is marked oth any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Be HENRY ADAMS SARAH WROTEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23F LAWS POINT ROAD, SELBYVILLE, DE. 19975 JOAN D. ADAMS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) DELAWARE VETERANS CEM! 4/26/04 MILLSBORO, DELAWARE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician MOXIL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobasco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 110 or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient Certification: To 1 Yes /2**♂**No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DS36/2 3111 30. Name and advess of peren who completed cause of death (Item 23a) (Type, Print) Dr Bedin, MD 21811

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene 2001

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	Diam'r.		1. Decedent's Name	e (First, Middle, La	st)					:	2. Dete of Deet Month	Dev	Yeer	3. Time of Death	1
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	Examir		4a Fecility Neme (II	f not Institution, giv	e street end number	r)			4b. City, Tov	wn, or Loc	ation of Deeth	on of Deeth 4c. County of Deeth			
			Ruxton Ce	enter					Dent			Caro	line		
4	Funeral		5. Social Security N		6ex 7. A □M 2.53CF		lest birthdey)	If Under 1 Months [	Year If Under 2 Deys Hours	Min.	8. Date of Birth (Month, Dey,	Year)	9. Birthpla Count	ace (State or Fore	ign
	Director		206-12-225	51	LIM ZLAF	85	Yrs.			6-18-1918 Virginia					
	pu .		Usual Residence of 10a. Stete	10b. County		10c Cit	y, Town or Loc	ation					10	Od. Inside City Limi	ite
	aryta Sho	<u> </u>					ringto					1 ☐ Yes 210XNo			
	ha N	š	DE 10e. Street end Nun	Kent		паг	Tilgeo	10f. Zip C	da		14	og. Citizen of	After Count		
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	aath	Funeral Director	1241 Gall	Lo Road	12. Was Deceden	t Ever in II	S 12 W	19952		nin? (Snac	ify Voc or No	USA 14 Bac	e - America	an Indian	
	ite m	Š	11. Maritel Status	ed 2 Married	Armed Forces	?	3. If	Yes, specify	t of Hispenic Orig Cuben, Mexican	, Puerto R	ican, etc.)		ck, White, e		
20	Ts of	J.	3 ☑ Widowed		If Yes, Give		1	☐ Yes 22	No Specify:			Specif	Whi	te	
21215-0020	filad within 72 hours eftar daath with tha Meryland Hygiana. Ither than "natural", or flerna 23a or 28e-f show ent, the Medical Examiner must be notified at	To Be Completed by	- A	15. Decedent's Ed			16a. Deced	ent's Usual (	Occupetion			6b. Kind of B	usiness/Indi	ustrv	
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212	with the same	E	Elementery/Secon	ndary (0-12)	College (1-4or	5+)	Homem	aker				Home			
9	Hyg offi-	0	17. Father's Neme (	First, Middle, Last)			TIO III O III		18. Mother	r's Name (	First, Middle, N		ne)		
<u>a</u>	ould be i Mental I mrked of	0 8	Masten Wa	ade Hash					Coria	a Eva	line (W	ard)			
a S	should and Men marke umatic	-	19a. Informant's Na	me/Relationship (	Type, Print)		19b. Mailing	Address (S	treet end Numbe	r or Rurel	Route Number,	City or Town,	State, Zip	Code)	
Ž	27 le		Jerry Ande	erson - S	on		101 N	orth S	treet Ha	arrin	gton, D	E 1995	2		
ē,	f Haalth frem 27 other tr	ļ	20a. Method of Disp	osition		20b. P	lace of Dispos emetery, crem	ition (Name	of r place) O		Date 2	0c. Location -	City or Tow	vn, State	
Ê	Pegas nent of int: If Ite iry or o			☐ Cremation 3 ☐ 5 ☐ Other (Specifi	Removal from State	9			<i>rpiece)</i> Cer .st Churc		29-04 N	otting	ham.	ΡΔ	
Baltimore, Maryland	parmit. Pegas 1 and 2 should be filad within 72 hours eftar death with tha Menylar Daparment of Haalith and Mental Hygiana. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	21. Signeture of Full	7		7			ddress of Facility						
ä	Dap Imp			1. 0 1	1/2//					.,				ont Hwy.	
			02a Baril Enter th	de disconsista	aliantions that source	d the death			uneral H			ington			
			shock, or hear	t failure. List only	plications that ceuse one cause on eech	line.	i. Do not onto	tile illoge c	i dying, suon es c	cardiac or	respiratory arre	31,		Approximate Intervel Between Onset end Death	
٠,	Physician /Medical		Immediate Cause (I	Final					1		. 1	,		1	
	Examiner		disease or condition resulting in death)  a Cerebro Vascular accident  Due to (or es e consequence of):											days	
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	nsit ad	edicai Examiner			b	5							i		
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o	the d y tha	ys	Part II. Other signific	cent conditions of	ontributing to death	out not rest	liting in the uni	derlying caus	e given in Part I.			No.		the cause of deat	
	that bed b	Y									1 🗆 Ye	8 STONIO	3   Probe	ibiy 4 🗆 Officio	19911
Sp.	Tha law raquiras that the sta has been signed by th page 2 should be datache	d by									24a. Was an	eutopsy	24b. Wer	e autopsy findings	s
် ဂ	raq beer shou	Completed							<del> </del>		perform	ed?	com	lable prior to pletion of cause eath?	
ě	a lav has ge 2	m D									SHAR	Au			
			05 Was seen refere	ad to modical							1 Yes		11.	Yes 2□ No	
5	Physician: rthis cartific ral diractor,	Be C	25. Was case referrence examiner?	1	Hospital:	·	FD/0 4 -414	a□ DD4	Aut 5 in		Check only one				
ō	Physical distribution	5	27. Menner of Deeth		1 Inpat		ER/Outpatient 28b. Time of				e 5 ☐ Resider				-
ה ס	Aftar fune	盲	1 Natural	5 Pending investigation	28e. Date of Inj (Month, De	ey Year)	Injury	м	Injury at Work? 1 ☐ Yes 2 ☐ N			,,			
Division	or Attending P setter daeth. I Director: Affar t d in by the funera	Certification:	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not be		iurv - At ho	me. farm. stre	et, factory, o			f. Location (Str	eet and Numb	er or Rural	Route Number.	-
5	Dire Dire	ert	4 Homicide	determined	building, e	c. (Specify	)	,,, -			City or Town,				
	Hospital 24 hours Funeral taly filled	2	29a. Certifier	1 Certifying Ph	ysiclan: To the best	of my know	vledge, deeth	occurred at t	ne time, date end	f place an	d due to the car	use(s) and ma	nner es sta	ted.	-
	24 h Fun ately	edicai			niner: On the basis of and manner s	of exeminat									
	To the Hospital or within 24 hours efter To the Funeral Director Complately filled in E								License number 29d. Date signed (Month, Dey, Yeer)						
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		-	30. Name end eddre	see of pareon who	completed sauce of	death (Itam	23a) /Tupo B			- 7		710	1/0	7	
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	Sta Registr			APR 282		me	19	Ann	1/2/						

DHMH 16 Rev 6/95

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H rtificate of I	lealth and N Death		ene 2004	15398
	Physici //Medic		Decedent's Name (First, Middle, La     Richard Samuel					2. Date of Death Month April 23	Day Year	3. Time of Death 12:10 AM M
7	Examir		4a. Fecility Name (If not institution, given Wicomico Nursing H			4b. City, Town, or Salisbury	Location of Death		4c. County of Death	
	Funeral Director		216-09-6099	Sex 7. Age 12	e (In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth Cou	place (State or Foreign intry) Md.
	72 hours after death with the Maryland netural; or items 23a or 28a-f show allcal Examiner must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  Md. Wicomic	20	10c. City, Town or L	у				10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 2	al Dire	1734 Crestwood (	Circle		10f. Zip Code 218	04	10g	. Citizen of What Cou USA	intry?
980	72 hours after death with the Marylan netural, or items 23e or 28a-f ehow digal Examinative motified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent If Amed Forces?  1 2 Yes 2 N If Yes, Give Year or Dates:	1000	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
21215-0036	within ane. than	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0·12)	ducation ade completed)  College (1-4or 5	(Give	dent's Usual Occupa kind of work done of DO NOT use retired Civil Serv	furing most of work )	ing 16	b. Kind of Business/Ir	
Maryland 2	d be filed ental Hyg ked othe c event,	To Be Co	17. Father's Name (First, Middle, Last Frank Atkinson	)			18. Mother's Nam	e (First, Middle, Ma		<u> </u>
Mary	nd 2 shoul lith and Mi 27 is marl r treumati		19a. Informant's Name/Relationship (			-			ity or Town, State, Zij	
Baltimore,	Pages 1 and 2 nent of Health ant: If Item 27 i		20a. Method of Disposition 1 Burial 2 X Cremation 3 C 4 Donation 5 Other (Special	Removal from State	20b. Place of Dispo cemetery, cre		9)	Date 200	c. Location - City or To Delmar, De	own, State
Balt	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Lice		1 1	2. Name and Addres	eral Home	, Inc.		
· ·	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ATHE	the death. Do not ente.  ROSCUER a consequence of):	ter the mode of dying	ROIOVA		DEERSE	Approximate Interval Between Onset and Death
,09/8	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
O. BOX 68	death certiff e attending id for use as	Physician/Medic	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 14 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy			23d. Date of delive	ery Day Year
J.	sign sign d be	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute to the	
II Hecords,	10 -	Completed				<u> </u>		24a. Was an autopsy performed	prior to co death?	psy findings available impletion of cause of
ion of Vital	Attending Physician: The death. sctor: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day	y 28b. Time o	f 28c. Injury Work	r: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how i	e 6 ⊡Other (Specifinjury occurred	y)
Division	in Direction	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura tate)	il Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Unsortionly 2 Medical Exam	ysician: To the best on niner: On the basis of and manner state	examination and/or in	n occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the caused at the time, date	e(s) and manner as si and place, and due to	tated.  the cause(s)
,	To With	Σ	29b. Signature and title of certifier			29c. License	number		Date signed (Month,	
4	INA	1	30. Name and address of person who	completed cause of de		Print)		10 11		
	Sta Registr	te ar	31. Date filed (Month, APR 23	32. Registra	r's Signature	Span				

R. Atkinson

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Division of Vital Records, P.O. Box 68760	Hospitel or Attending Physician: The law requires that the death certificate he evented

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Stephen Bowser 04-02770 RPD 1 - For State Registrar

Baltimore, Maryland 21215-0036

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Menta Certificate of Death

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Reg. No.	(-m	U	U	64	l l	5	14	U

The law requires that the death certificate be exacuted attending physician and for use as the burial-transit Box 68760 P.0. signad by the Division of Vital Records, this certificate has al director, page 2 After thi

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 April 22, **Physician** Stephen L. Bowser 0512 P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 578-80-6476 1**∑** M 2□ F 47 Director August 5, 1956 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location nthan "natural", or Itams 23a or 28a-f show the Modical Exprimer must be notified at 10d. Inside City Limits Prince George's Oxon Hill Maryland 1 Yes 2 □ No Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5022 Boydell Avenue 20745 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene. I other than "natural", or Ital V Yes 2 No 1r Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor D.C. Public Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental h Ronald Bowser Barbara Swann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Shadonna L. Norwood (Daughter) 5022 Boydell Avenue Oxon Hill, Maryland 20745 20a Method of Disposition 20b. Place of Disposition (Name of permit. Pagas 1 Department of Ho Important: If iter any injury or oth 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park May 1, 2004 Landover, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HINT PLACE, N.E. WASHINGTON, D.C. 20019 T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impediate Cause (Final **Physician** a disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 any leading to min soleta cause. Enter Underlying Cause (Disease or injury Disa to (or as a consecuence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 1 X Yes 2 🗆 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 2 1 ☐ Inpatient 2 ☐XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 5:00 P 1 ☐ Yes 2 No investigation 2 Accident Director: 28f. Location Titreet and Number or Rural Route Number City or Town, State) 6 Could not be determined Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. 4 Homicide after street Washington D.C. within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 200 April 23, 2004 O.C.M.E. XX Name and address of person who completed cause of Penn Street, Baltimore, Maryland 21201 SONI LA lod (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2 9 ZUU4

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 15401 State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:55 P M Teresa Briscoe April 2004/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick Calvert County Nursing Center, Inc. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👽 F 98 578-38-5622 Yrs June 11, 1905 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ed other than "netural", or items 23a or 28e-f show event, the Medical Examiner must be notified at 1 XYes 2 No Directo Calvert St. Leonard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #10 Westerd Blvd. 20685 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 WNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "netural", or Item any injury or other treumatic event, the Medical Entergene 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give The Year or Dates: Specify: Black ρ 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Hecht Department Store 7th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Clark Harriet Butler ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #10 Westerd Blvd. Agnes Grayson (Niece) St. Legard, Maryland 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Xaurial 2 □ Cremation 3 □ Removal from State April 23, 2004 Washington, D.C. Mt. Olivet Cemetery ' 4 ☐Donation / 5 ☐ Other (Specify) 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signatury of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician Deus Chronic resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate saude. Entail Unorthing Cause (Disease or injury that initiated events resulting in death) Last Anemia Due to (or as a consequence of): Examiner the death certificate be executed burial-transit Dementia and Due to (or as a consequence of): Traci Records, P.O. Box 68760, the attending physician Urinar ection Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 € No certificate 1 ☐ Yes Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-20-04 D. Shal D 50290 MD 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fredesich 110, loina MD HOSP 20678 RD Shah Dhiven 31. Date filed (Month, Day, Year) APR 2 9 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryland	/ Depa	rtment of H tificate of L	ealth and I D <i>eath</i>		giene 20 ( Reg. No.	)4 15402
,	Physici /Medio		Decedent's Name (First, Middle, Last,		oddu			2. Date of Dea Month April 2		3. Time of Death 1:37 P M
	Examin		4a. Fecility Name (If not institution, give Southern Marylar	nd Hospital		4b. City, Town, or Clir	nton			George's
	Funeral Director		5. Social Security Number 216-04-8550 6. Se	7. Age (In yrs. las ☐ M 2 🛣 86	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Yeer) 8, 1917	Birthplace (State or Foreign Country) India
	be filed within 72 hours after death with the Maryland half Hygiene. do other than "naturel", or items 23e or 28e-f show event, the Marieral Examiliers and event, the Marieral Examiliers and the restilled at	Director	10a. State 10b. County  Maryland Prince (  10e. Street and Number		Town or Lo	Greenk	œlt	10g. Citizen of Wha	10d. Inside City Limits 1 1√2 Yes 2 □ No 3. Citizen of What Country?	
	death with ems 23e or er - ust be	ineral DI	7538 Mandan Ro	Dad.  12. Was Decedent Ever in U.S. Armed Forces?	13. V	20 Vas Decedent of His Yes, specify Cubar	9770 spanic Origin? (S	pecify Yes or No	Indi	.a. American Indian, White, etc.
9000	nours after urel', or Ita	d by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:	o riioan, sic.,	Specify:	ast Indian
121	C * 1	Completed by Funeral	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give i life. L	ent's Usual Occupa kind of work done d OO NOT use retired) HOMEMAKE1	luring most of wor )	rking	16b. Kind of Busin	ŕ
ਲੂ	should be filed within the Mental Hygiene. marked other then matic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event, the Minatic event.	To Be Co	17. Father's Name (First, Middle, Last)  Itty Mathews	-			18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	acc
Mary	d 2 shouth and N 7 is mai		19a. Informant's Name/Relationship (7) Queenie Armstron						er, City or Town, Sta	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic a <u>once</u> .		20a. Method of Disposition  1	20b. Plac	e of Dispos	sition (Name of patory or other place National	e)	Date /2004	20c. Location - City Laurel,	y or Town, State
Balt	Departr Departr Importe any Inji		21. Signature of Puneral Service License	gend-					e Funeral am MD 207	
8760,	Ireate be executed  Mamma Mamma Mamma  Physician and street transit street buriat transit street management and street management an	edical Examiner	23a. P. A. Enter the disease, or compounce, or heart failure. List only of a mediate Cause (Final isease or condition resulting in death)  Sequentially list conditions, and any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a consequence.  Due to (or as a consequence.	Cava	0-0	1 /	- /-	ula A	Approximate Interval Batween Onset and Death
P.O. Box	to the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending procompletely filled in by the funeral director, page 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1□Live birth 2□Fetat de 4□Pregnant at time of deat 9□Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
rds, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions con	ntributing to death but not resulting	ng in the un	derlying cause give	n in Part I.			te to the cause of death?  Probably 4 Junknown
l Recc	iicien: The law re certificate has be rector, page 2 sho	Completed	Upper G1	blooding,	pele	plusa		24a. Was a autop perfor 1 ☐ Yes	an 24b. Were sy prior deat 2 No 1	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
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Division of Vital Records,	to the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ation: To	1 Yes, 2 No Carter 1 V Natural 5 Pending 2 Accident investigation		VOutpatient 3b. Time of Injury	28c. Injury Work	at Nursing H		lence 6 Other (Sow injury occurred	ъресity)
Divis	To the Hospitel or Attentivity of Attentivity 24 hours after deal To the Funeral Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number o m. State)	r Rural Route Number,
	n 24 hou n 24 hou ne Fune oletely fii	Medical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medicel Exemi	rsician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the o rred at the time, o	cause(s) and man <i>n</i> e date and place, and	r as stated. due to the cause(s)
	vithi To ti	Σ	29b. Signature and title of certifier	6	_	29c. License	number 279	02	29d. Date signed (M	onth, Day, Year)
	(2)		30. Name and address of person who co	CHANDR	A.		9131 Pis	cataway	Road, Cli	nton MD 20735
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 7 2004	31. Registrar's Signatur	Ches	les				

State of Maryland / Department of Health and Mental Hygien@ [] [] [

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Leo Donald Blagburn, Jr. April 23, 2:28A 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George ff Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 2, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2□ F 578-50-1051 66 1937 Director Washington, DC. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1X Yes 2 No Director Maryland Prince George Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4717 Keppler Place 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1⊠Yes 2⊡No 1955 If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black <u>^</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) Coflege (1-4or 5+) U.S. Postal Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leo D. Blagburn, Sr. Beatrice McCall 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 I Darrell L. Blagburn/Son 2222 Wood Duck Court; San Leandro, CA. 94579 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Fort Lincoln Cemetery April 30,2004 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 21. Signature of Funer Service License 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** CORONARY ARTERY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEART FAILURE CONGESTIVE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to compfetion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 28b. Time of fniury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier within 2 To the and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40324 APRIL, 23, 2004 ddress of person who completed cause of death (Item 23a) (Type, Print) TERRY JODRIE, MID. 7503 SURRATTS ROAD, CLINTON, MARYLAND 20735 31. Date filed (Month, Day, Year) Registrar's Signature State APR 2 7 2004 Registrar

		1- State of Maryland / State of Maryland / Registrar	Depa Cer	rment of Health and N 9 1-21-05 tas tificate of Death	lental Hygi	ene2004	15404		
		Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death		
Physi /Med		Romeo C. Bruce			April	21, 2004	4 3:20 P <sup>M</sup>		
Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
		12216 Wynmore Lane		Bowie	100	Prince (			
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Mar. 14	9. Birth (Cou 1932 Ph	place (State or Foreign intry) Llippines		
70		Usual Residence of Decedent							
anylar show	_	10a. State 10b. County 10c. City, Total	wn or Loc	cation			10d. Inside City Limits 1 X Yes 2 No		
8a-f	Director		Bow			000000000000000000000000000000000000000			
with the or 2	Dir.	10e. Street and Number		10f. Zip Code 20715	10	g Citizen of What Cou Philippine	S		
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ire, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f. show other traumatic event, the Medical Examinar must be notified at	by Funeral	Armed Forces?  1 Never Married 2 Married 1 Yes, Give 14 Server Dates:	lf	Yes, specify Cuban, Mexican, Puerto  ☐ Yes 2 No Specify:	Rican, etc.)	Black, White	, etc.		
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aryland should be and Mental marked o	P	Vicente Bruce			a Cadiz				
Aar 2 sh 2 sh and is m	1			g Address (Street and Number or Rur					
e, N 1 and Health mm 27 ther tr				6 Wynmore Lane		, MD. 207			
Pages nent of nnt: If its		1 Burial 2 XCremation 3 Removal from State	ery, crem	atory or other place)					
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Baltimore, Ma Finit. Pages 1 and 2 Defartment of Health a Important: If Item 27 is any injury or other tra	Suc	> CBusin Towell	6	512 NW Crain H	wy. Во	wie, MD.	20715		
Physicia /Medica Examine	al	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Gastric Ca	nce		or respiratory arres	st,	Approximate Interval Between Onset and Death M O S •		
8760, cate be executed shysician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Leatese or injury that initiated events resulting in death) Last Cause (and the cause in the caus							
P.O. BOX 6 It the death certific by the attending parched for use as	by Physician/Medicai	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal deat 4   Pregnant at time of death 9   Unknown		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Yea				
rds, F quires tha n signed uld be del	ed by P	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause given in Part I.		accoluse contribute to			
Division of Vital Records, for Attending Physician: The law requires that death.  Director: After this certificate has been signe in by the funeral director, page 2 should be or	Completed				24a. Was an autopsy perform	24b. Were aut prior to co death?	opsy findings available ompletion of cause of		
Vital F vician: Th certificate rector, pag	Be	25. Was case referred to medical			h (Check only one,	)			
Of \ Physic this c	6	1 Yes 2 No Hospital: 1 Inpatient 2 ER/C				ce 6 Other (Special	fy)		
Junera Junera	ion	27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred			
Division of Vital Re to the Hospital or Attending Physician: The within 24 hours after death. Fo the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre		28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,		
Hospita 4 hours Funeral ely fillec	edical C								
To the I within 2. To the I	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month,	Day, Year)		
- 5 0		I Sahada She For 30		H0055927		April 23	2004		
(2)		30. Name and address of person who completed cause of death (Item 23a	) (Type, F			p-11 2J	, 2004		
				Hospital Drive	Chever	rly,MD.			
Regi	State strar	31. Date filed (Month, Day, Year) APR 2 6 2004 32/Registrar's Signature	5	u II					

	1	State of Maryland / Department of Health and M  State of Maryland / Department of Health and M  Certificate of Death		iene 2004	15405
	-	I. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	th Day Year	3. Time of Death
Physiciar /Medica	1	Richard Boone Jr		2-04	3:40A M
Examine		a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	_
		Southern Maryland Hospital Clinton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince (	
Funeral Director		238-46-8791 1\overline{\overline{\text{M}}} M 2□F 71 Yrs. Months Days Hours Min.	(Month, Day 12-4-		thplace (State or Foreign cuntry) <u>h Carolin</u> a
within 72 hours after death with the Maryland and and then "neturel", or items 23a or 28e-f show had added Evantinat must be multipled at	-	Jsual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
Department of Health and Mental Hygiene. Importent: If item 23a or 28e-f show Importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumatic event, Ital Medical Evantrar must be multified at once.	ğ	Md Prince George's Ft Washington			1 ZYes 2 ☐ No
or 28e	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	ountry?
ustk	<u>e</u>	6336 Rosecroft Drive 20744		USA	
E I	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Decedent of Hispanic Origin? (Spr. 1) Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
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icalE	te g	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ina	16b. Kind of Business	/Industry
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3	5	12 Horse Groomer		Horse Rac	cing
even	Be		McDan	_	
natic	2	Richard Boone DOILY  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run  19c. Ma			Zip Code)
treur		Denise L Spruill, Daughter 226 Pennsylvania A			
other	1	20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or	
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injui 9	П				l Services
1 2 3		1722 North Ca	pital	Street NV	
		23 Part Enter the disease, or comprehations that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	rest,	Approximate Interval Between Onset and Death
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esn J	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de Month	elivery Day Year
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detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
gog ∣.	by	Takin. Olidi Sigilili Santa Sa	1 🗆 Y	es 2□No 3□P	robably 4 Zillinknown
shoule	Completed		24a. Wasa	an 24b. Were a	utopsy findings available
page 2	E C		autop perfor	sy prior to death?	completion of cause of
or, pa	မ င	25. Was case referred to medical 26. Place of Deat	1 ☐ Yes		s 2□No
s certificate has t lirector, page 2 s	To Be	examiner?  1 Yes 2 D No Hospital: 11 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho			ecify)
		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?		ow injury occurred	
ne fur	atlo	2 Accident investigation M 1 Yes 2 No			
irecto	edical Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet and Number or F n, State)	Rural Route Number,
lled ir	S		and due to the	acusada) and manner	ar stated
Fune tely fi	lica	29a. Certifier  (Check only one)  1 Gertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time,	date and place, and du	e to the cause(s)
o the	Mec	29b. Signature apprtitle of certifier 29c. License number		29d. Date signed (Mon	
ō		Hart Jellen Co454	F	APRIL, 22	2,04
0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
10		980/ Cherry Ave 3-4/ 8/1/00/5 PRING NO 20902			
Stat		31. Date filed (Month, Day, Year) APR 2 6 2004 32. Registrar's Signature			
Registra	ar	APR 2 0 2004 Marie			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** lan 2:55 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) Examiner Prince George's Hyattsville St. Thomas More Nursing & Rehab. Center Birthplace (State or Foreign Country) If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Min. Hours 1□M 2X F Sep. 8, Wash. 579-12-3509 Director Usuel Residence of Decedent filed within 72 hours efter death with the Marylend 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Modical Examinar must be notified at 1 XYes 2 No Director DC Washington 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20011 United States 5866 Eastern Ave., N.E. Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: **Black** Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Private 10th Housewife permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 is marked other: eny injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Ruth Jenkins Wallace Grav ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5866 Eastern Ave., N.E. Wash., DC 20011 Joan B. Nickens - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 \$\overline{X}\$ Burial 2 □ Cremation 3 □ Removal from State 4/26/2004 Wash., DC Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home 20019 ewant 4001 Benning Rd., N.E. Wash., DC Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Theroscleratic Cardio Vascular disease /Medical Immediate Cause (Final disease or condition resulting in death) Examiner upertensia Examine attending physicien end for use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1L Yes 2KINC 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.
To the Funeral Director: After this certifice completely filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 □ Residence 6 □Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. Medicai 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 0022708 12 1328 Southern Ave STE IP Jo7 washyta 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Meer Said Zo Nozi MD 31. Dete filed (Month, Day, Year) APR 2 6 2004 32. Registrar's Signature Registrar

		-	1- For State of Maryland / Depar	tment of H		ental Hygier	21111L	15407
1	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  George H. Butler			2. Date of Death Month April 19	2004 Year	3. Time of Death 9:00 A M
	Examin	er	Anne Arundel Medical Center	4b. City, Town, or Annapo	olis	A	4c. County of Death nne Arunde	
	Funeral Director			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye March 17	ar) 9. Birthp Coun 1909 Mary	lace (State or Foreign try) y Land
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Loca MD Prince George's Upper M				1	0d. Inside City Limits 1 □ Yes 2 □ No
	ath with the Marylan 23a or 28a-f show	I Director	10e. Street and Number 15311 Leeland Road	10f. Zip Code 2077	74	_	Citizen of What Coun	try?
980	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show fra Modical Example of sual by notified at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 1 → No	as Decedent of His Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B1	
21215-0036	e filed within 72 ho Il Hygiene. other than "natur vant, tre Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 4th  16a. Deceder (Give kir life. DC) Farm		ation luring most of worki )	ng 16b	Kind of Business/Ind	lustry
Maryland 2	be filed tal Hyg d othe evant,	To Be C	17. Father's Name (First, Middle, Last) Arthur Butler		18. Mother's Name	(First, Middle, Maid ler	den Sumame)	
	12 hai		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailing  James Butler/Nephew 16100	) Cambrid	lge Court		ty or Town, State, Zip aryland 20	
Baltimore,			20a. Method of Disposition  1				Location - City or To	
Baltii	Department of Important: If i any injury or one.		21. Signature of Funeral Service Licensee 22.1	Name and Addres	is of Facility $J$ .	B. Jenkir	s Funeral Maryland	Home
Ant	znysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		g, such as cardiac c			Approximate Interval Between Onset and Death
	/Medical- Examiner		resulting in death)  Due to (or as a consequence of):					
3760,	death certificate be executed e attending physician and dor use as the burial-transit	Ical Examiner						
O. Box 68	death certific e attending p id for use as i	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E	Ectopic pregnancy Other (specify)	.==		23d. Date of delive Month	ery Day Year
rds, P.	quires that n signed b uld be deta	by	A contract of the same	derlying cause give	en in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
tal Records,	iician: The law requires that the certificate has been signed by th rector, page 2 should be detache	e Completed	25. Was case referred to medical		26 Place of Death	24a. Was an autopsy performed 1 Yes 2 2	prior to con death?	psy findings available mpletion of cause of 2 No
of Vital	8 8	To B	examiner?		<sup>9</sup> r: 4 ☐ Nursing Ho		6 □Other (Specifi	r)
Division	or Attending Phy after death. Diractor: After the	Certification:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be		Yes 2□No	28f. Location (Street	t and Number or Rura	il Route Number,
Ō	i Sir te		4   nomicide building, etc. (Specify)	occurred at the tin	ne, date and place,	City or Town, Sa		tated.
	na Hospital within 24 hours a To tha Funaral I completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or inverse and manner stated.	estigation, in my or	pinion, death occurr	ed at the time, date		the cause(s)
<i>_</i>	in 8		Merousen, FUS		46002		4/19/04	
	19		30. Name and address of person who completed cause of death (Item 23a) Type. P	rin Panhwa	y ann	orpolis, M	)	
*5	St Regist	ate rar	31. Date filed (Month, Day, Year)  APR 2 6 2004	المريك				

Please Type or Print in Black Indelible Ink	Ensure All Copies Are Legible.
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			1 - For State Registrar	State of	Maryland	d / Depa <i>Cer</i>	rtment of F tificate of	lealth and N Death		giene 2001	15408
ı	Physicia	an	Decedent's Name (First, Middle,      A X/A NICONI, IA/A I		III CD				2. Date of De Month	Day Year	A - A 14
9	/Medic Examin		LAVANION WAI  4a. Facility Name (If not institution,	give street and num	ber)			or Location of Death	April	4c. County of De	ath
				S. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Bird	Wicom.	/CO rthplace (State or Foreign
	Funeral Director		222-01-0558	1 🔀 M 2 🗆 F	95	Yrs.	Months Days	Hours Min.	Dec. 1	y Year)	elaware
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City	. Town or Loc	ation				10d. Inside City Limits
	ith the Marylar or 28a-f show	to	Delaware Sussex	7		Laure					1 □ Yes 2 ZWNo
	th the or 28a	irec	10e. Street and Number			naaro	10f. Zip Code			10g. Citizen of What C	Country?
	ath will	ral	501 West 7th St				1998			USA	
_	Items	Funeral Directo	11. Marital Status 1 □ Never Married 2 Marrie	Armed For				Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)		ite, etc.
2-003p	be filed within 72 hours after death with the Maryland Hydiene.  4 other then "neturel", or tiems 23a or 28a-f show do ther then "neturel", or tiems 23a or 28a-f show event, if a Madical Examination used to mailified a	by	3 Widowed 4 Divorced	If Yes, Give Year or Da	9	1	☐ Yes 2 No	Specify:		Specify: Bl	ack
<u>ה</u>	"netur	Completed	15. Decedent's (Specify only highest			(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most of work	king	16b. Kind of Busines	
7	iene. then the M	dwo	Elementary/Secondary (0-12)	College (1-	4or 5+)	Custo		u)		Laurel Scho	ool District
פב	be filed trail Hygie of other event, II	Be C	17. Father's Name (First, Middle, La	ast)		0000	<i>5</i> 44 411	18. Mother's Nam	e (First, Middle,	, Maiden Sumame)	JOI BIBLITOL
Ya	2 should be and Mental Is marked reumetic ev	일	Edward			Hearn		Minnie		Bel	
Z Z	s 1 and 2 should if Health and Men item 27 Is marke other treumetic		19a. Informant's Name/Relationshi Ruth Belle/ wife	p (Type, Print)			,			er, City or Town, State, Delaware	
ē,	s 1 and of Health item 27 other tr		20a. Method of Disposition			ace of Dispos	sition (Name of plate)	- T-	Date	20c. Location - City of	
aitimor	Pages nent of l ant: If it ury or o		1		tate	w Zion	Ch. Cem	et. 04/2	4/2004	Laurel, Del	aware
pair	permit. Pages Department of I Important: If ite any injury or o once.		2 . Sig lature of Funeral Service Li	11/14	lley	JO	LLEY ME	EMORIAL	CHAPEL		Salisbury, MD 21801
	^		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that can nly one cause on ea	used the death ach line	. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
)	Physician Medical		Immediate Cause (Final disease or condition resulting in death)		sevi					-	
	Examiner			_	or as a consequ	_	AILUR	G			
L.	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consequ		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			· · ·	
_	and and Ill-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		PIRA or as a consequ		PNE	UMONIA	-		
8/60	certificate be executed ding physician and use as the burial-transit	dlcal		d. ALZ	ZHELM	IERS	DEM	MENTIA			
POX 6	leath certifica attending ph I for use as th	ician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo						23d. Date of de	alivery
מ כ	the atten	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 □ Fetal ant at time of de wn		Ectopic pregnancy Other (specify)	y 		Month	Day Year
ŗ.	w requires that the de been signed by the should be detached	/ Phys	Part II. Other significant condition	s contributing to de	ath but not resu	ılting in the un	derlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
SD	requires een sign nould be	ed by							1 🗆 1	Yes 2 No 3 F	robably 4 DUnknown
ecords	a S C	Completed		_					24a. Was	osy prior to	utopsy findings available completion of cause of
E E	ate pag									ormed? death?	s 2□No
VItal	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	patient 2 🗆 8	ER/Outpatient	3□ DOA Ott	26. Place of Dea		one) dence 6 □Other (Sp	ecifu)
וס ר		-	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date o		28b. Time of Injury	28c. Injui	ry at		how injury occurred	outy)
UIVISION	tend leath tor: the	ertification;	2 Accident investiga 3 Suicide 6 Could no	ition				Yes 2 □No	00(1) (1)		
<u> </u>	I or Atten after deatl Director: I in by the	ertifi	4 Homicide determin	280. Place	of Inju <b>ry</b> - At ho ig, etc. <i>(Specify</i>	me, farm, stre	eet, factory, office	have all the second of the sec	City or Tox	Street and Number or F wn, State)	Rural Houte Number,
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: -eampletely I lled in by the	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the ba	sis of examinat	wledge, death ion and/or inv	occurred at the til	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
	ithin 2	Med	29b. Signature and title of certifier	and mann	er stated.		29c. Licens	se number		29d. Date signed (Mor	ith, Day, Year)
1			> Shan 1	Y.D.			057	7952		4/201	2004
	5#		30. Name and address of person w		of death (Item	23a) (Type, I	Print)	Vishara	MO	21804	
	Sta Registr		31. Date filed (Month, Day, *ear). APR 2	32. Re	egistrar's Signat	ture &	Span	K	-		

		1 - For State Registrar	State of	Maryland / Do	epartment of Certificate of			giene 0 0	+ 15409
Physic	ian	Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month April 1	th	3. Time of Death
/Medi	cal	Harold G. 4a. Facility Name (If not institution, given		tley	4h City Town	or Location of Dea		9. 2004 4c. County of D	8:00 PM M
Exami	ner	9952 Oak Terrace		Der)		Springs		Wicomi	
Funeral Director		5. Social Security Number 6. S		Age (In yrs, last birth	day) If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9. 9, 1941	Birthplace (State or Foreign Country)
pu s		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Maryli f sho	ō			Mardela					1 ☐ Yes 2 ☑ No
r 28a-	Director	Maryland Wicomi  10e. Street and Number	.00	Margera	10f. Zip Code		1	0g. Citizen of What	Country?
ith wit		9952 Oak Terrace			21837			USA	
15-0036 72 hours after death with the Maryland "natural", or ltems 23s or 28s-f show alloal Examinations to institute at	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced	Armed Ford 1 Tes 2	2 X No	13. Was Decedent of If Yes, specify Cut		Specify Yes or No- to Rican, etc.)		merican Indian, thite, etc. White
-00-		15. Decedent's E	Year or Da	16a. D	ecedent's Usual Occu	pation		16b. Kind of Busine	
21215-0 3 within 72 ho piene. r then "natur the Medical.	Completed	(Specify only highest gr Elementary/Secondary (0-12)		4or 5+)	Give kind of work done ife. DO NDT use retire	during most of wo ad)	orking		,
nd 2121 e filed within al Hygiene. cother then '	Com	12		Fan	ily Servic	Y			Memorial Park
	Be	17. Father's Name (First, Middle, Last Beecher G.	) Benti	lev		18. Mother's Na Marga	me (First, Middle, i ret. –		ombs
Tore, Marylan ges 1 and 2 should be nt of Health and Mental i: If item 27 is marked or or other traumatic eve	2	19a. Informant's Name/Relationship			Mailing Address (Stree				
Manual Sulth an 12 s 27 ls r trau		Lisa M. Lansdale			9 Moreland				5005
Baltimore, bermit. Pages 1 an Department of Heal mportent: If item; any injury or other		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other pla			20c. Location - City	
Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci		tate	-		22,2004	Salisbu	y, Maryland
Baltimo		State lurg of Funeral Service Lice	nsee		22. Name and Addr	ess of Facility			Association
ш аода		Nonce of the	noon	> CFSP	501 Snow	Hill Road	d, Salisb	ury, Mary	land 21804
Physician /Medical	ш. Д	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (o	ch line.  POXEM  r as a consequence of	IA				Approximate Interval Between Onset and Death
. Box 68760, death certificate be executed  se attending physician and dir use as the burial-transit	dical Examiner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequence of	:	PulmoNA	RY Di.	SEASE	
.O. Box 6 the death certif y the attending tched for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bir	ome of pregnancy th 2 Fetal death nt at time of death vn	3 □Ectopic pregnand 5 □ Other (specify) _	у		23d. Date of Month	delivery Day Year
<u>~</u> 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	þ	Part II. Other significant conditions	contributing to dea	tth but not resulting in ti	ne underlying cause gi	ven in Part I.	23e. Did tot	,	to the cause of death?  Probably 4 □Unknown
Rec The law te has b	Completed						24a. Was a autops perform	y prior ned? death	autopsy findings available o completion of cause of ? es 2 \( \) No
f Vital ysicien: ] ysicien: ] is certifical director, p	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only on		
	2	1 ☐ Yes 2 ☑ No		patient 2 ER/Outp	atient 3 DOA		lome 5 heside		pecify)
ding After fune	Certification:	27. Manner of Death  1			ury Wo M 1 □			w injury occurred	
Divisi To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		4 Homicide determined	286. Place of building	Rural Route Number,					
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	nysician: To the bas miner: On the bas and manne	est of my knowledge, on the sis of examination and/ or stated.	death occurred at the ti or investigation, in my	me, date and place opinion, death occi	e, and due to the ca urred at the time, da	ause(s) and manner ate and place, and c	as stated. ue to the cause(s)
To the within 2 To the comple	ž								nth, Day, Year)
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SIM			DLASH	ADE 10	S PINEL	BLUFF 1	ED SAL	LISBUL	204 Y MD 2801
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2	2 2004 P	gistrat's Signature	D Apo	uls			

		-	For State Registrar	State of	of Mar	-	artment <i>tificate</i>			and M			7 0 11	4	15410
	Dhusisi		1. Decedent's Name (First, Midd	ile, Last)							2. Date of De Month		y Year		Time of Death
	Physicia /Medio	al -	Marie Mai Bet								APRIL		2004		9:10a M
	Examin	er	4a. Facility Name (If not institution				4b. City, To		Location	of Death					
			Berlin Nursin 5. Social Security Number	g & Kenab		Iter (In yrs. last birthday)	Berli		If Under	24 Hrs.	APRII. 21, 2004  Jeath 4c. County of Death Worcester  Hrs. 8. Date of Birth (Month, Day, Year) 7-24-1918  100. Citizen of What Count USA  110. Specify: White, e Specify: Whit		(State or Foreign		
	Funeral Director		222-10-4430	1 ☐ M 2 🛣 F	85	Yrs.	Months	Days	Hours	Min.	7-24-1	9 18"	0	De De	e.
			Usual Residence of Decedent											-,	
	arylar show d.at	_	10a. State 10b. Count			IOc. City, Town or Lo									nside City Limits ☐ Yes 2 X No
	the Marylar 28a-f show	ecto		Wicomico		Delmar	10f. Zip C	\				10a C	times of What C	J	
	with t	Funeral Director	10e. Street and Number	n J			218					iog. Ci		ourniy:	
	eath	erai	30951 E. Line	12. Was Dec		er in U.S. 13. V			spanic Ori	gin? (Spe	cify Yes or No	-	14. Race - Am		dian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "natural", or items 23e or 28e-f show is marked other then "natural", or items to sell the national cannot be a marked other than the Medical Exact for the national cannot be a marked as a marked other than the Medical Exact for the national cannot be a marked or the marked of the cannot be a marked or the marked or	by Fun	1 □ Never Married 2 Ma 3 □ Widowed 4 □ Divorce	If Yes, G	2 X No ive		fYes, specif 1 ☐ Yes 2]		Specify:	i, Puerto I	Rican, etc.)		Specify-	ite, etc. White	e
5-0036	72 hours "natural", Jical Exe		15. Decede	nt's Education		16a. Deced	dent's Usual	Occupa	ition	e and suspended		16b. K	(ind of Business	s/Industry	1
215	hin 7. 9. 9n "n	Completed	(Specify only night Elementary/Secondary (0-12)	est grade completed, College	(1-4or 5+)	life. L	DO NOT use	retired)	) -	I OI WORKII	ng	_			
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⊒ pu	ould be filed Mental Hygid arked other atic evant, to	Be	17. Father's Name (First, Middle William Frede								11111111				
Ze Ze	should be nd Menta marked imatic ev	ဥ	WIIIIalli Frede			10b Mailin	a Addropp (	Stroot a						Zin Code	
MARIE M., Maryland	9 E M =		Charles W. Bet		a d									Zip Code	=/
ຼ ຄົ	tem 27		20a. Method of Disposition			20b. Place of Dispo	sition (Name	of of						r Town, S	State
S.	Pages nent of h nnt: if ite ury or of		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other		State	Crematory				4-22-	-04	Delr	nar, De		
BETTS, Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other		21. Signature of Funeral Service				. Name and Short	Addres Fun	s of Facilit	Home	e, Inc.				
- I	40200		23a Part 1. Enter the disease	or complications that	caused th	ne death. Do not ent	13 E.	Gree	ve S	t. De	elmar,	De.	19940	Appi	roximate
	Dhysisian		Immediate Cause (Final	st only one cause on	each line.	1 51	A	2	1	Ois					val Between et and Death
	Physician /Medical		disease or condition resulting in death)	ato	(on as a	consequence of):	er	<u> </u>	eu	UIS	Carre			,	100019
	Examiner		Sequentially list conditions	b. #	The	soscle-04	te C	RUC	lioua	saul	len N	130	ner	7	cars,
-	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a	consequence of):	Mei	01 4	_					(	U
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to	Jia	consequence of):	Ivie	ui	45					7	
8760,	ate be executed thysician and the burial-transit				(5, 25 2										
687	ficate phys s the	edic		d											
Вох	th certi ending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or			Ectopic preg	gnancy						livery Day	Year
P.O. B	w requires that the death certifics been signed by the attending ph should be detached for use as t	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Preg 9□ Unki		me of death 5	Other (spec	cify)					Month	Day	real
	s that ned b e deta	by Pt	Part II. Other significant condi	tions contributing to	death but	not resulting in the u	nderlying cau	use give	n in Part I		23e. Did t	obacco	use contribute t	o the cau	use of death?
rds	quire en sig										10	Yes 2	.□No 3□P	robably	Unknown
Division of Vital Records,	law re as be 2 sho	Completed											24b. Were a	utopsy fi	ndings available
Ä	The ate ha	ĕ									perfo	rmed?	death?		
/ita	sician: The law s certificate has b lirector, page 2 s	Be (	25. Was case referred to medic examiner?					0.1		of Death	(Check only o	one)			
of \	Physic this c	ပ္	1 Yes 2 No		Inpatient				1200	-				ecify)	
n C	ding F	ion	27. Manner of Veath	28a. Date (Mo	nth, Day	Year) 28b. Time of Injury	M 200	c. Injury Work 1 □ Y	(? Yes 2 🔲		EGG. Describe	now inju	ily occurred		
isic	Attandestification of the Attan	ficat	3 Suicide 6 Coul	d not be 28e. Place	e of Injun	y - At home, farm, str								<i>lural R</i> ou	ite Number,
Ö	s after s after al Dire	Certification:	4 Homicide	build	ding, etc.	(Specify)					City or To	wn, Stat	θ)		
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		al Examiner: On the		xamination and/or in									
	To the within To the compl	Me	29b. Signature and title of certific	MMedle.	1	mD	29c.	License	number	69		29d. Da	ate signed (Mon	thy Day,	Year)
i	[mp	1	30. If me and address of person	on who completed cau	use of dea	afh (Item 23a) (Type,	Print)	20	9	Eso.	stal	He	ber	19	7944
	Sta		31. Date filed (Month, Day, Yea	2 2 2004	Registrar	's Signature	9 1	bos	KI	-		(	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Regist	al	711 13	~ ~ 6007	/										

			1 - For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of H	lealth and Death	Mental Hygi Rec	ene 200	4 15411
Į.			Decedent's Name (First, Middle, La	ist)				2. Date of Death	1	3. Time of Death
	Physici	•	Mildrod V	Carmichael				April 2	20 2004	8:52pm M
	/Medic Examin		4a. Facility Name (If not institution, gir			4b. City, Town, or	r Location of Deat		4c. County of Dea	
	Examilia	CI	Drings Coorgo	Woonital		Chever	lv		Prince	George
	Funeral		Prince George 5. Social Security Number 6.	Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9 Ri	inthplace (State or Foreign Country)
*	Director		579-26-8713	1□M 2XF 81	Yrs.	Months Days	Hours Min.	(Month, Day,		th Carolin
			Usual Residence of Decedent					1066 10	1322 8700	
	ylan		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Ma B-f-	ţ	Md Prince	George CAP:	ITOL	HEIGHTS				1 No Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	1) wil	aic	819 Balsamtree	Dr.		20743		U	SA	
	dea	Funerai	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S	specify Yes or No- to Rican, etc.)	14. Race - Am Btack, Wh	
9	or its	E,	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No		1 ☐ Yes 2X No	Specity:	, ,	Specify:	
8	ours iral',	d by	3 ₩ Widowed 4 Divorced	Year or Dates:					B.	lack
21215-0036	72 h	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give	dent's Usuat Occup kind of work done	during most of wo	rking 1	6b. Kind of Busines:	s/industry
7	Aithin han 'e.	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired				
7	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or itams 23a or 28a-f ehow ent, tha Medical Examinat must be notified at		12th 17. Father's Name (First, Middle, Las	*1	R00	k Binde		me (First, Middle, M		inting Off.
Sur	be fi	Be	_	9					alderi osmanoj	
Maryland	ould Mer Park natic	P	Jake Page	(Time Driet)	10h Mailie	n - Address /Cares	Ola Cra		City of Town State	Zio Codol
Vai	12 sh and reun		19a. Informant's Name/Relationship		1			ural Route Number,	•	
6	l and lealth im 27 her t		Brenda J.W. Br	own(daughter	) 5736	Southe sition (Name of	rn Ave	SE Wash	DC 2001 0c. Location - City o	1 9
0	ges t of h		1X Burial 2 ☐ Cremation 3	☐Removal from State	emetery, crei	matory or other plac				
Ë	. Pa tmen tant: jury		*4 □Donation 5 □Other (Spec	7 Res	urrec	tion Ce	m Apri	1 28,04	Clintor	n Md. Fun.Service
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "natural", or itams 23a or 28a-f ehow any injury or other traumatic event, the Medical Examination and be nutilised at ance.		21. Signature of Fundar Service Lice	young						
	orn = e a		your 1	yours	71	9 Kenne	dy St.	NW Wash	ington,	DC 20011
,			23a. Pa 1 Enter the disease, or yor shock, or heart failure. List ont	nplications that caused the death y one cause on each line.	. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory arres	31,	Approximate Interval Between Onset and Death
	Physician		disease or condition	a FATAL C	ARDIA	C ARR	HYTHMI	A		31001 2110 30211
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
В	LAGITITIE		Sequentially list conditions,	b	ACCOUNT NAME OF					
	po is	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	sence of):					
	ecute and tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):					
8760,	requires that the death certificate be executed signed by the attending physician and hould be detached for use as the buriat-transit			000 10 (0. 20 2 00.1004	20.100 0.7.					
87	physi the I	dical		d						
9 x	ertific ding p	Me	IF FEMALE:	23c. If yes, outcome of pregna	ncv				004 5-11-014	
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 gronths?	1 Live birth 2 Fetal	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	Day Year
o.	the s	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eatin 51	Other (specify)				
<u>α</u>	that the death certifued by the attending detached for use as		Part II. Other significant conditions	contributing to death but not resu	ulting in the u	Inderiving cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Records,	ires t signe	l by			<b>-</b>			1 ☐ Yes	s 2□No 3□F	Probably 4 XUnknown
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H		ပ္ပ							No 1 ☐ Ye	s 2 No
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Homitali		Oth		ath (Check only one	)	
)t	Physician: this certific ral director,	မ	1 ☐ Yes 2 No		ER/Outpatie		4   Nursing i	Home 5 Residen		ecify)
Ē		O.	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	Wor		28d. Describe how	v injury occurred	
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Division of	after death after death Director: d	Certification:	4 Homicide determine		me, rarm, st	reet, ractory, office		City or Town,		Rural Route Number,
	Hospital or 4 hours afte Funeral Dire tely filled in b		00 0 0 W 0 W 10 10 1	M I - I - I - I - I - I - I - I - I -		(h. a				
	To the Hospital or Attenwihn 24 hours after deal To the Funeral Director: completely filled in by the	ledicai		Physician: To the best of my kno iminer: On the basis of examina and manner stated.						
	thin the	Mec	29b. Signature and title of cartifier	Cu Dan Luna	(IIn)OC	29c. Licens	se number	29	d. Date signed (Mor	nth, Day, Year)
	Twith To		(1) 12.	CALIRA VEN	100/18(11	MADILI	715			
Λ	8		00 News and distance	nompleted sever of death "	124) (7 -	Prior)	110		4 - 25	-04 MD 20740
R	(5)		30. Name and address of person whe			ENBELT K	PD #11-2	100	Flat Dine	ALLAC (IM
	0		CHITRA VENKAT 31. Date filed (Month, Day, Year)	22. Registrar's Signa	ture	LIVEULI I	w u-3	WII	MYC IAXX	THU DO PACE
	Sta Regist		APR 2 9 200	22. Registrar's Signa	ha	12.				
					A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Table 1				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day **Physician** April 22 2004 1:00 AM CARTER MARGARET /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Larkin Chase Nursing Home Prince Georges Bowie If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 28 ☐ F 76 Director 267-38-0434 1927 Florida Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. Stete 10b. County 28a-f show the Medical Examiner must be notified at No Yes 2 No Funeral Director Lanham Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mentel Hygiene. ŏ 10130 Annapolis Road 20706 U.S.A. 238 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Merried 2 ☐ Married ð Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify Specify: δ 3 Widowed 4 ☐ Divorced "natural". Be Completed 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) 8th College (1-4or 5+) Private Housewife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) end Mentel is marked Lorenza Washington Joseph Bolden 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health en important: If Item 27 is any injury or other trauping. 60 10130 Annapolis Road Lanham, Maryland 20706 Lorenza Wilds/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/30/04 Farmingdale, New York Long Island Nat'l Ceme 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Pneumonia Examiner Due to (or as a consequence of): Lung Cancer or Attending Physician: The law requires thet the death certificete be axecuted for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): pue Box 68760, physician Physician/Medical Due to (or as e consequence of) 23b. Did tobecco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 M Unknown 1 Tes 2 No δ 24b. Were autopsy findings available prior to completion of cause of death? Aftar this certificate has been si funaral director, pega 2 should 24a. Was an autopsy performed? Be Completed 3K 140 1 ☐ Yes 2 ☒ No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28c. Injury et Work? 5 Pending investigation 1 Natural Injury To the Hospital or Attending within 24 hours efter death.

To the Funerel Director: Afte completaly filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier 29c. License number

State

Registrar

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Don Yablonowitz M.D.

7404 Executive Place # 502 Lanham, Maryland 20706

4/24

0

31. Dete filed (Month, Day, Year)

APR 2 8-2004



State of Maryland / Department of Health and Mental Hygiene 001 15413 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death **Physician** 2004 Willie Mae Curseen April 12:20 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Manor Care Rehab. & Nursing Home Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Mar. 8, 19 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Deys 1 □ M 2 TF Yrs. 1931 Virginia Director 73 232-56-8825 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mantal Hygiana. Internation of Heatth and Mantal Hygiana. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show 1 XYes 2 No Director Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1438 Bangor St., S.E. 20020-4915 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicon, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian, Black, White, etc. African 1 ☐ Yes 2 ☐MNo If Yes, Give Yeer or Dates: 1 Never Married 2 N Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: δ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Henderson Elizabeth Lee ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph P. Curseen, Sr. 1438 Bangor St., S.E. Wash., DC 20020-4915 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State **Department** 4/29/04 4 Donation 5 Other (Specify) Mt. Olivet Cemetery Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home (speul 4001 Benning Rd., N.E. Wash., DC nter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Arteriosclerotic Cardiovascular Disease Examiner Due to (or es e consequence of): Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Congestive heart failure Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Diabetes; Hypertension; Peripheral Vascular Disease Anoxic encephalopathy/History Cardiac Arrest 1 Tes Zix No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2√ No 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending after death.

I Director: After the but the further than the the further than the further t 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D23588 April 24, 2004 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Stomierowski, M.D. 6111 Executive Blvd., Rockville, MD 20852 Louise M. 31. Date filed (Month, Day, Year) 32. Registrer's Signature State APR 2 7 2004 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Berlin Mary land Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min OCT 22, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2\ F 89 MARYLAND Director 213-24-4378 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show r then "neturel", or Items 23a or 28e-f showing the Mydical Examinations! be notified at 1 X Yes 2 ☐ No Director DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19975 RT. 2 BOX 224B USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ۾ Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event 9DC8. Be .TOHN BRADFORD ELIZABETH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT V. CAMPBELL/SON 777 SATURN DR., UNIT 101, COLORADO SPRINGS, CO 80906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State `4 □ Donation 5 □ Other (Specify) NEW HOPE CEMETERY 4/23/04 WILLARDS, MARYLAND 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1EUMONIA Pnysician /Medical Die to (or as a consequence of): 12004 1230 Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury One to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/MedIcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □bnknown 1 Yes 2 No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho certificate 1 Yes 2 No Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 this nours after death.

nerel Director: After this

filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

10/20/1515

15/16

State Registrar

30. Name and address of person who completed cause of completed (Item 23a) (Type, Print) MA 32. Registrar's Signature

1209 COASTAR HIGHWAY, FRUYCK

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22 Month **Physician** Year 2156 M 04 MARVIN CARTER 2004 LEE JR. /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 54 4/3/5414 NIOSMICO Rea IDAM TENINSULA Medical 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**⊠**M 2□F MARYLAND **Director** 13, 217-24-9682 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Important: If item 27 Is marked other than "natural", or Itams 23a or 28a-f sho any injury or other traumatic avant, Ir a Modical Examinar must be notified at 1 Yes 2 No Director DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 173 SHADY PARK 19975 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be fited within 7 and Mental Hygiene.

s marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) DIVISION VICE PRESIDENT MANUFACTURING 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental I-7 Is marked ot CARTER LYAL **GLADYS** HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 Is VIRGINIA S. CARTER/WIFE 173 SHADY PARK, SELBYVILLE, DE. 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ST. JOHN'S CEMETERY 4/27/04 \* 4 ☐ Donation \_5 ☐ Other (Specify) ELLICOTT CITY, MD 21. Signature Funeral Service Licentee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause deach line. Immediate Cause (Final disease or condition resulting in death) Onset and Death CARDIAC ARRHYTHMIA Physician /Medical Due to (or as a consequence of): **Examiner** HYPOTENSION Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and I-transit Due to (or as a consequence of): physician a the burial-1 P.O. Box 68760 Physician/Medical for use IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed REGURGITATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1'

Inpatient 2 □ EP/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 22, 2004 30. Name erson who completed cause of death (Item 23a) (Type, Print) 100 E. PIETIE m.D. 32. Registrar's Signature 31. Date filed (Month State 2004 Registrar

arte, Maron

Harry Samuel Dawson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02835 State of Maryland / Department of Health and Mental Hygiene RPD Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 25, 2004 **Physician** 0610 P M Harry Samuel Dawson /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1፟፟፟∭ M 2□ F 234-24-4787 Jan. 21, 1923 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "neturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Directo Prince George's Maryland Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5904 Temple Hill Road U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ⊠Yes 2 □ No 1943— If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Specify. δ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene Importent: If item 27 is marked other than "ne any injury or other traumatic avent the ponce." College (1-4or 5+) Elementary/Secondary (0-12) Accounting D.C. Transit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marion O. Dawson Roca Bohrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5904 Temple Hill Road, Temple Hills, MD 20748 Gladys Penny Dawson - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4/29/2004 Brentwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4739 Baltimore Ave., Hyattsville, MD 20781 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ▶ Yes 2 □ No certificate has birector, page 2 s 1 Yes 2 🗌 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA tor: After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 2 Accident

Attending Physician: To the Hospitel o within 24 hours aff To the Funeral Di completely filled in

investigation 6 Could not be

2510 28e. Place of Injury - At home, farm, street, factory, office building, etc. | Specify) determined rosder

1 Yes 2 700

Le

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as dated.

2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

3 TSuicide

29a. Certifier

Medical

4 Momicide

29c. License number

Many 29d. Date signed (Month, Day, Year)

O.C.M.E.

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE MORE Milem

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) APR 2 9 2004



		1 For State	State of Maryland / De	epartment of Health and its Sertificate of Death	Mental Hygie	ne 2004 1541
Physic	cian	1. Decedent's Name (First, Middle, Last,		orimodio or Dodin		Day Year
/Med Exam	lical	VERNA 4a. Facility Name (If not institution, give	DUNHA street and number)	M 4b. City, Town, or Location of Deat	April 21	, 2004 10:00 p <sup>N</sup> 4c. County of Deeth
Exam		5011 Edmonston F	Road	Hyattsville		Prince George's
Funera Directo		3//-10-330/	7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 25,	9. Birthplace (State or Foreig Country) 1919 Kentucky
ould be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or Items 23a or 28a-1 ahow atte event, If a Medical Examirar mast be rediffied at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince (	George's Hyatt	r Location sville		10d. Inside City Limits 1 ∑ Yes 2 ☐ No
or 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
s 23e		5011 Edmonston I		20781	inecify Vos or No	U.S.A.  14. Race - American Indian,
2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f ahow aumatic event, it a Medical Examires man he notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 No Specify:</li> </ol>	o Rican, etc.)	Black, White, etc.  Specify: White
hin 72 hora. B. natura Medical	Completed	15. Decedent's Edu (Specify only highest grad	cation   16a. Do (C) le completed)   (C) College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of wor e. DO NOT use retired)	rking 16b	. Kind of Business/Industry
of 2 should be filed within 72 hours aft th and Mental Hygiene. It is marked other than "natural", or traumatic event, if a Medical Examitraumatic event, if a Medical Examitraumatic event.	Con	8	Hom	emaker		Own Home
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lith an 27 is a		Russell D. Dunham		1 Edmonston Road,		
rmit. Pages 1 and 2 should partment of Health and Men portant: If Item 27 is marke portant: If item 27 is market in jury or other traumatic		20a. Method of Disposition	20b. Place of D	sposition (Name of crematory or other place)	Date 20c	Location - City or Town, State
Page nent o int: If iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		ncoln Cemetery 4/2	6/2004 B	rentwood, Maryland
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Furrerar Service Licens	90 / 17/3/43	22. Name and Address of Facility Ga 4739 Baltimore Ave		-
g &		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not	enter the mode of dying, such as cardiac		Approximate Interval Between
Physiciar /Medica Examine	l. r	Immediate Cause (Final disease or condition resulting in death)	Cardiac Arrythm  Due to (or as a consequence of):  Coronary Diseas		у	Onset and Death
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Physician: this certificantal director,	To E	examiner? 1 ☐ Yes 2 💢 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	itient 3 DOA Other: 4 Nursing H	lome 5 🖾 Residence	6 ☐ Other (Specify)
tending leath. tor: After the fune	Certification:	27. Manner of Death  1 🖾 Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Yeer) 28b. Tim Inju	ry Work? M 1 □ Yes 2 □ No	28d. Describe how in	njury occurred  t and Number or Rural Route Number,
To the Hospitel or At within 24 hours after of the Funeral Direct completely filled in by	Certi	4 Homicide determined	building, etc. (Specify)		City or Town, St	tate)
the Hos in 24 ho the Funk pletely f	edical			eath occurred at the time, date and place r investigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
To t To t	×	29b. Signature and title by certifier	Charole	29c. License number  D-00/885	0	Date signed (Month, Day, Year)
90		30. Name and address of person who de Chuntung Changchie	en, M.D. 8824 Cun		te D, Berw	yn Heights, MD 20740
S	tate	APR & 6 2004	32. Registrar's Signature			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	arylanu / L		tificate of	Death		Reg. No		+ 15418
ì	Physici	an	1. Decedent's Name (First, Middle, La	st)			Ne	36505	2. Date of De Month	Da		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, giv	e street and number)				Location of Death	APRIL		. County of Dea	31
	Examin	ei		HOPKINS	HOSPIT	AL		TIMORE			ALTIMOR	
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last bir	_	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08-201			thplace (State or Foreign
	Director		096-48-8258 Usual Residence of Decedent		49	113.			08-20-1	954	PUE	RTO RICO
	ryland how		10a. State 10b. County		10c. City, Town	n or Loc	cation					10d. Inside City Limits
	8a-f	cto	MD WICOM:	CO	SALIS	BUR	1					1 X Yes 2 □ No
	with the or 2	Funeral Director	10e. Street and Number	7.m			10f. Zip Code	0.7		10g. Cit	tizen of What C	ountry?
	death ms 23	erai	608 HAMMOND STREI	12. Was Decedent B	Ever in U.S.	13. W	218 Vas Decedent of H	U4 ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No	)-	USA 14. Race - Am	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23e or 28e-f ehow entry for other traumatic event. The Medical Example retained to apply our other traumatic event. The Medical Example retained at ODGE.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo			sn, Mexican, Puerto Specify: PUE			Black, Whi	te, etc. WHITE
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Банттог	permit. Pages Department of I Important: If it eny injury or o		1∑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	ý)	cemeter	y, cřem IS C	atory`or other plac EMETERY	04-28	-2004	SALI	ISBURY,	MARYLAND
Da	permit Depar Impor eny in		21. Signature of Funeral Service Licer	en to	wy	70	5 EAST M	ss of Facility BOU AIN STREE	T, SALIS	BURY		
	Physician		23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused and cause on each line				g, such as cardiac		rrest,		Approximate Interval Between Onset and Death  2 YEARS
	/Medical Examiner			Due to (or as a	a consequence	of):						
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	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as:	a consequence	ot):						
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.C. BOX	The law requires that the death cert ite has been signed by the attendin age 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 SHO 9 ☐ Unknown	23c. If yes, outcome of Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other <i>(specify)</i>				23d. Date of de Month	livery Day Year
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	cian: ertifica sctor, I	Be C	25. Was case referred to medical examiner?					26. Place of Death				
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0	Attending Physician: if death. ector: After this certific by the funeral director,	tlon	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day	Year) 200. I	ime of njury	Worl		28d. Describe	now injur	y occurred	
DIVISI		Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 200 Place of Inju	ıry - At home, fa .: (Specify)	rm, stre			28f. Location (: City or To	Street an wn, State	d Number or Ri	ural Route Number,
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76	Ò		30. Name and address of person who 8ASIJAR SAFAR		eath (Item 23a) (	Type, P	Print)	STREET	1			ARYLAND ZIZE
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			For State Registrar	State	of Marylan	d / Dep <i>Ce</i>	artment of F	lealth and N Death		giene 200 Reg. No.	14 15420
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath	3. Time of Death
	Physicia		Elmer Dale	Eby					April	22, 2004	8:00 AM
	/Medic Examin		4a. Facility Neme (If not institution,				4b. City, Town, o	r Location of Death		4c. County of I	
			1015 Tyler Ave	nue			Salisb			Wicomi	
	Funeral			S. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year) 9.	Birthplace (State or Foreign Country)
	Director		334-34-3846	1⊠M 2□F	64	Yrs.	,		August :		Maryland
	p .	-	Usual Residence of Decedent  10a, State 10b, County		10c. Cit	y, Town or L	ocation				10d. Inside City Limits
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	28a-f	ect	Maryland Wicom	1CO	Sa	lisbu	10f. Zip Code			10g. Citizen of Wha	at Country?
	with	ă		10			21804			USA	
	death with the Maryland ms 23a or 28a-f ahow	Funeral Director	1015 Tyler Avent	12. Was De	cedent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	- 14. Race -	Americen Indian,
^	r then	필	1 X Never Married 2 ☐ Marrie	Armed I d 1 1 Yes	Forces? : 2□No COō Give		If Yes, specify Cubi	an, Mexican, Puer	o Hican, etc.)	Black,	White, etc.
	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	lf Yes, C Year or	Dates: Gua		1 ☐ Yes 2 🄀 No	Specify:		Specify:	White
5	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed	d)	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of wor	king	16b. Kind of Busin	ess/Industry
V	ithin nen Mer	d d	Elementary/Secondary (0-12)		(1-4or 5+)		_			Health	
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and	be find H	Be	17. Father's Name (First, Middle, L	_	·			Elsie	Albe		oder
Ž	d Mer narke	2	Paul Raymo: 19a. Informant's Name/Relationsh		by	10h Mai	ling Address /Street			er, City or Town, Sta	
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e,	ages 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiene.  If it imm 27 is marked other than "natural", or items 23a or 28a-1 ahow it it imm 27 is marked other than "natural", or items it maral to inclified at or other traumatic evant, the Medical Examinat maral to inclified at		20a. Method of Disposition	yior (S	20b. F	Place of Disc	osition (Name of		Date	20c. Location - Cit	
altimor	permit. Pages 'Department of h Important: If its any Injury or of		1 ☐ Burial 2 🖾 Cremation 1 ☐ Donation 5 ☐ Other (Sp	ecify)	m State	lisbur	y Crematory or other pla	ry Apri	L 23, 20	04 Salis	bury, Maryland
gall	permit. Depart Import any Inj		21. Signatur Funera Service L	le Clou		_	22. Name and Addre Holloway 501 Snow	Funeral H	Home Pro	fessional bury, Mar	Association
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Ä	The la ate has page 2	E C		110,000						rmed? dea	r to co <i>m</i> pletion of cause of th?  Yes 2□ No
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Division of	Attanding Physician: ir death. actor: After this certific by the funeral director,	⊢	27. Manner-of Death	28a. Da	te of Injury onth, Day Year)	28b. Time	of 28c. Inju			how injury occurred	
0	nding tth. r: Afte e fun	atio	1 Natural 5 Pending 2 Accident investig	,	onui, Day 19ai)	Injury		Yes 2 □ No			
NIS	Atta	if	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned   200. Fig	ice of Injury - At h	ome, farm, s	street, factory, office		28f. Location ( City or To		or Rural Route Number,
	tal or rs afte al Dir ed in	Certification:									
	To the Hospital or Attending Physician: The lav within 24 hours after death.  To the Funeral Director: After this certificate has sompletely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Sone)	xaminer: On the	the best of my kno basis of examina anner stated.	owledge, dea ation and/or	ath occurred at the ti investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
	To th within To th Somp	Ž	29b. Signature and titte of certifier		<u> </u>		29c. Licen	se number		29d. Date signed (	Month, Day, Year)
1	-MP		1 ( ludu	1			H.	1647		4/23/	oy
5 )	IVA		30. Name and address of person	who completed ca	ause of death (Ite	m 23a) (Type	e, Print)  Geroll St.	Salist	oury v	315 W	,01
	Sta	ate	31. Date filed (Month, Day Year)	3 200 4 32	. Registrar's Sign	ature	4 100	1/1			
	Regist		AFR Z	3 2004	Year		pypod	KN			

			For	State of Marylan				d Mental Hyg	giene	15101
			State Registrar		Ce	rtificate of I	Death	2. Date of Dea	Reg. No.2 U U L	
п	Physicia	an	1. Decedent's Name (First, Middle, Last Elsie Rosalee		nnis			Month	Day Yea	17 43 M
п	/Medic Examin		Elsie Rosalee  4a. Facility Name (If not institution, give		11112	4b. City, Town, or	Location of D	Peath	4c. County of De	
	Exam.		Peninsuh Regional	Medien Co	111	346	sharp		KIOM	ved
	Funeral Director		219-05-3540	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days	Hours A	Min. 8. Date of Birth (Month, Day)  Jan . 28	1922 Ma	linthplace (State or Foreign Country) aryland
	and ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary	io	Maryland Wicom	ico	Не	ebron				1 ☐ Yes 2 No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	eath w		7941 Belle Aver	nue 12. Was Decedent Ever in U	I.S. 13.	218 Was Decedent of H		? (Specify Yes or No-	U.S.A	nerican Indian,
336	be filed within 72 hours after death with the Maryland Hygiene. Indepty than "natural", or itema 23a or 28a-f show to other than "natural", or itema 23a or 28a-f show event, I as Medical Examiner man be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 10  If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, P Specify:	? (Specify Yes or No- uerto Rican, etc.)	Black, Wi	
Maryland 21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of	working	16b. Kind of Busines	ss/Industry
2	within ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired nestic	1)		None	
2 2	filed v Hygie other t	CO	5 17. Father's Name (First, Middle, Last)		וסמ	Hestic	18. Mother's	Name (First, Middle,	None  Maiden Sumame)	
<u>a</u>	ed ital	To Be	Granville Horse	ey Sr.			Mar	y Gale		
ary	0.00.00		19a. Informant's Name/Relationship (7	ype, Print)	1	,		r Rural Route Numbe		, Zip Code)
	s 1 and 2 if Health item 27 l		William F.Ennis 20a. Method of Disposition			1 Belle	Ave.H	ebron, Md	. 21830 20c. Location - City	or Town State
0 0	Pages nent of hant of hant: If ite		1 Murial 2 ☐ Cremation 3 ☐	Removal from State	cem etery, cre	matory or other place		4/241		
Baltimore,	그런근 중 .		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service License</li></ul>			ill Mem.  2. Name and Addre		n / /04-	Hebron,	MQ.
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Box	leath certificat attending phy I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		75.			23d. Date of c	delivery
о. М	the death y the atte ached for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
Records, P.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the buflat-transit	by	Part II. Other significant conditions or		sulting in the t	underlying cause giv	en in Part I.	23e. Did to		to the cause of death?  Probably 4 Unknown
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Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		at 25 DOA Oth	00	Death (Check only or		
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<b>,</b>	To th withir To th comp	Me	29b. Signature and title of certified	<u>.</u>		29c. Licens D 25	e number 036	4	29d. Date signed (Mo	
Ç			30. Name and address of person who of	completed cause of death (Item	m 23a) (Type	Print) SHOR	UZ Dr	ive. SAL	-15BUR	1. m. Pot.
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 7 2	32. Registrar's Sign		Sport				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registra Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles Theodore Fawks, Jr. 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | Oct 22, 1927 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □XM 2 □ F 209-20-1658 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once. 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Directo PA Franklin Waynesboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17268 14066 Wayne Highway USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Soldier US Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles T. Fawks, Sr. Mary Feathers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14066 Wayne Highway Waynesboro, PA 17268 Lucille M. Fawks wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) St. Andrew Cemetery May 4, 2004 Waynesboro, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc anette M Felmen 50 S Broad ST Waynesboro, PA 17268 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac occespiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Serror Physician egvor Dom /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-translt Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown Š Part II. Othersia ificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed þ neumong 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2□ No 1 🗌 Yes 1 🗌 Yes 2 - N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 2 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Mann Death 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 ☐ Medical Exam er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifig

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 3 2004

ORIGINAL

32 Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 10:15 a<sup>M</sup> April 24, 2004 Falcone Lawrence /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner 6107 40th Avenue Hyattsville Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. April 10, 1916 Birthplace (State or Foreign Country)
 Italy 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 141-01-7452 88 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehow the Medical Examiner must be notified at 1 XYes 2 No Maryland Prince George's Hyattsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6107 40th Avenue Itema 23a 20782 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1942— If Yes, Give 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Bleck, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 HNo Specity: If Yes, Give Year or Dates: 1945 3 ☑ Widowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) r then Elementary/Secondary (0-12) fited within Hygiene. Mailer Newspaper 2 should be filed w and Mental Hygiei Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Philip Falcone Marv Confalcone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is nany njury or other traum Mary Scaldaferri - Daughter 14603 Baugher Drive, Centreville, VA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/27/2004 Fort Lincoln Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee udette 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Few Days Hypoxia /Medical resulting in death) Due to (or as a consequence of): **Examiner** Respiratory Failure Months Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (Ur as a consequence of): Examiner the death certificate be executed burial-transit Chronic Obstructive Pulmonary Disease Years and Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by Prostate Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Heart Failure 24a Was an page 2 s has autopsy performed? Yes 2 2 No certificate 1 ☐ Yes Division of Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nuhl D 393 April 26, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rashid Baghai, M.D., 344 University Blvd., West, Ste. 324, Silver Spring, MD 20901 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artmen					iene g. No. 2	2004	15	424
			1. Decedent's Name (First, Middle, La	st)					2	2. Date of Deat Month	h Dey	Yeer	3. Time	of Death
	Physici /Medio		MARY	VIS	FITZE					4	20	2004	6:45	A. M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Death	h	
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	Funeral		5. Social Security Number 6. S		e (In yrs. last birthda	/) If Under Months	1 Year Days	If Under	Min.	B. Date of Birth (Month, Day,	Year)	9. Birth Col	hplece (State untry)	or Foreign
	Director		220-05-0889		82 Yrs.				J	AN. 17	, 192	22 VIRG	GINIA	
	pug *		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location			-				10d. Inside	City Limits
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	ns 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Deced	ent of Hi	ispanic Ori	igin? (Spec	ify Yes or No-		. Race - Ame		
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Ba	permit. Page Department Important: If any injury or once.		21. Signardie of Fulleral Salvice Lice	2/2	2					ים כדו	VVIT	יור חד	100	75
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Вох	eath certific attending pl for use as t	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetal death	B □Ectopic pr					23	ld. Date of deli Month	ivery Day	Year
	e dea	Physician/Med	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of death	5 ☐ Other (sp	ecify)						,	
P.0	that the de ed by the detached	F.	Part II. Other significant conditions	contributing to death	out not resulting in the	underlying c	alise divi	en in Part I	1	23e. Did tob	oacco use	e contribute to	the cause of	f death?
S	ires ti signe sibe c	þ	Part II. Other significant senaturis	somming to double	Sattlet rootking in the	andonymg o	auto givi			1/	s 2 🖪		obably 4	
of Vital Records,	w requir been si should	ompleted								040 1460 0		Odb More av		as available
Sec.	e law has t	ldu								24a. Was a autops perforr	v .	24b. Were au prior to death?	completion of	cause of
HE HE		S								1 ☐ Yes	2 12 No		2 🗆 No	
Zi:	icien: certific ector	Be	25. Was case referred to medical examiner?	Hospital:			Oth	er		(Check only on				
ot	Physicien: this certific ral director,	10	1 Yes 2 No 27. Manner of Death	1 Empat			8c. Injun	vat		e 5 ☐ Reside 3d. Describe ho			city)	
	ding h. After fune	lo	1 ⊡Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year) Injun		Worl	k? Yes 2.⊟			, ,			
Division	if or Attending Fafter death. Director: After d in by the funer	Certification:	3 Suicide 6 Could not to	28e. Place of In	jury - At home, farm,	street, factory	, office		28	3f. Location (St		Number or Ru	ıral Route Nu	um <i>ber</i> ,
Ö	or A after Direct	erti	4 Homicide	building, e	tc. (Specify)					City or Towr	i, State)			
	pite ours berel fille		29a. Certifier 1 Certifying P	hysician: To the bes	of my knowledge, de	ath occurred	at the tin	ne, date an	nd place, ar	nd due to the ca	ause(s) a	nd manner as	stated.	
	e Ho re Fu	edical	(Check only 2 Medical Exa	miner: On the basis of and manner s	of examination and/or tated.	investigation	, in my o	pinion, dea	ath occurred	d at the time, d	ate and p	lace, and due	to the cause	∌(S)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	12 1/	\ \P	290	. Licens	e number		2	9d. Date	signed (Month	h, Day, Year)	)
	0		1 /2 /		- P.L		44	1428	73		41	122/0	01	
(	6001		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)			4		A	18 / 14	1 7 71	611
_			Robert Di	IKKIN	9733	1401	the	NAY	DIC	174	1.X1	17N M	DZL	2//
	Sta	ate	31. Date filed (Month Pay Year)	2004 32. Regid	rar's Signature	9 1	oou	6						

**ORIGINAL** 

इ.स.	Physici	an_	1 - For State Registrar  1. Decedent's Name (First, Middle, Last)		•			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir	al	Taft Green, 4a. Fecility Name (If not institution, give s	treet and number)		2. Date of Death Month   Day   Ac County of Takoma Park   M.   Vear   Vear   Month   Day   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Min.   July 6, 1943   Months   Days   Hours   Months   Days   Hours   Months	4c. County of De	ath		
	Funeral Director		Washington Adven 5. Social Security Number 578-56-1104  Usuel Residence of Decedent	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	(Month, Day, )	(ear) 9. B	tgomery inthplece (State or Foreign Country) ash., DC
	within 72 hours after death with the Maryland ane. then "naturet, or items 23s or 28s-f show the Musical Experiment mast be mutified at	Director	10a. State 10b. County  Maryland Prince  10e. Street and Number		ty, Town or Lo	M	t. Rainio		Citizen of What C	10d. Inside City Limits 1 □XYes 2 □ No
	23a or			ey P1., #102			20712	10		d States
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel, or items 23s or 28s-f show with injury or other traumatic event, the Mexical Expuritor mat be nutified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates:				Specify Yes or No- to Rican, etc.)	Specify:	nerican Indian, pite etc African American
215-0	thin 72 ho e. en "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done	during most of wo	rking 10	6b. Kind of Busines	
Maryland 21215-0036	l be filed wit ntal Hygien ed other th	Be	12th  17. Father's Name (First, Middle, Last)  Taft Green		M	aintenan		me (First, Middle, Ma	iden Sumame)	ivate
Maryla	nd 2 should th and Men 27 is marke 1 traumatic	To	19a. Informant's Name/Relationship (Ty) Ramona Green - W	oe, Print)				ural Route Number,	City or Town, State,	
Baltimore,	Pages 1 ar nent of Hea int: If Item iry or other		20a. Method of Disposition  1 XBurial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emoval mom State					Oc. Location - City o	
Balti	permit. Pages Department of I Important: If Iti eny injury or o		21. Signature of Fiuneral Service License	ewart III	٠	4001 Be	nning Rd	., N.E. Wa	sh., DC	ne 20019
	Physician /Medical Examiner	Examiner	shock, briean failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	e cause on each line.	Anio.	~ ?~	FUMB	MIA		Approximate Interval Between Onset and Death  DECEMBER 03
). Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Medical Exar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 \( \subseteq No	Due to (or as a consequence of pregnance of pregnance of pregnance of pregnance of depth of d	ancy	Ectopic pregnanc			23d. Date of de Month	
ds, P.O.	sign Sign d be	by	9 ☐ Unknown  Part II. Other significant conditions con		sulting in the ur	nderlying cause gr	ven in Part I.			to the cause of death?
Vital Records,		Completed						autopsy performe	prior to death?	utopsy findings available completion of cause of
Vit	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 25 No	ospital: 1 Plnpatient 2 🗆	ER/Outpatien	t 3 DOA Ott	100		ce 6 □Other /So	ecity)
Division of	ling h. After fune	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Inju Wo M 1	ry at rk?	28d. Describe how	injury occurred	
Divi	Hospital or Attenc 24 hours after death Funeral Director: stely filled in by the t		4 Homicide determined	building, etc. (Specif	(y) 			City or Town,	State)	
	he Hos in 24 hc he Fun pletely i	edical	(Check only 2 Medical Examir one)	er: On the basis of examina and manner stated.	ition and/or inv	restigation, in my	me, date and place opinion, death occu	e, and due to the cau urred at the time, date	se(s) and manner a and place, and du	is stated. le to the cause(s)
	To the Vithin 2 To the Complet	W	29b. Signature and title of certifier			29c. Licens		290	Date signed (Mon	oth, Day, Year)
	(4)		39. Name and address of person who con	mpleted cause of death (Item			A YE A	230 MA	kump Pf	RK Md og 12
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 2004	3 Registrar's Signa	ture	all s				1

		•	1 - For State Registrar	State of Maryla			of Health a of Death				104	15427
	Physici /Medio		1. Decedent's Name (First, Middle, Last Fannie Gholson	)					2. Date of De Month April		ď <del>0</del> 4	3. Time of Death 9:00 a M
	Examin		4a. Facility Name (If not institution, give Washington Adven	tist Hospita		Takon	wn, or Location on a Park			4c. County Montg	omery	
	Funeral Director		5. Social Security Number 6. Se 579-44-9166	7. Age (In yr	s. last birthday)  5 Yrs.	Months D	Year If Under Pays Hours	Min.	8. Date of Bin (Month, Da 08-02-	y. Year) -1908	9. Birthp Coun V1.	lace (State or Foreign itry) rginia
	e Maryland ta-f show	ctor	10a. State MD County Montgome		City, Town or Lo Silver			-			1	0d. Inside City Limits 1 1 Yes 2 □ No
	th with th	al Director	10e. Street and Number 901 Alcola Avenue			10f. Zip Co	902			10g. Citizen of V US		itry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural," or Items 23a or 28a-f ahow aumatic avent, the Modical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 W Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:		Was Deceden If Yes, specify  1 ☐ Yes 2	t of Hispanic Ori Cuban, Mexicar No Specify:		cify Yes or No Rican, etc.)	Blac	e - Americ k, White, Bla	
Baltimore, Maryland 21215-0036	I within 72 ho liene. r than "natur the Medical	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) OTh  College (1-4or 5+)		(Give		occupation done during mos retired) Practio			16b. Kind of Bu		dustry	
/land	e d fa b	To Be C	17. Father's Name (First, Middle, Last) Robert Washington	L					(First, Middle, ne Howa	Maiden Sumam ard	е)	
, Mary	and 2 sho raith and h 1 27 is ma er trauma		19a. Informant's Name/Relationship (7) William McIntosh/							er, City or Town, MD 207		Code)
more	permit. Pages 1 and 2 should Department of Heatth and Men Important: If Ikem 27 Is marke any injury or other traumatic once.		20a. Method of Disposition  1 △Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	Place of Dispo cometery, cre ashingt	matory or other	r place)		1/2004	20c. Location - Suitland		
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins F.H. 716 Kennedy St., Washington DC. 20011									
-	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the de ne cause on each line. a. Due to (or as a cons	>	ter the mode o	f dying, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical xecuted and all-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consi		url						1 week
O. Box 6	death certifi e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal death 3	□Ectopic pregr □ Other (speci		· ) \$		23d. Dat Mor	e of delive	ry Day Year
rds, P	quires that n signed b ud be deta	by	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying caus	e given in Part I.		23e. Did to			e cause of death? ably 4 Unknown
	i: The law requires that the cate has been signed by the page 2 should be detached.	Completed							24a. Was autop perfor 1 □ Yes	med? d	rior to con leath?	osy findings available inpletion of cause of
	rsician: Th	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2	☐ ER/Outpatier	nt 3 DOA	Out		(Check only o	<i>ne)</i> Jence 6 □Othe	or /Conside	.1
Division of	Attanding Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	-		Injury at Work?	2		now injury occurre		,
Ħ	j 를 를 드	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	reet, factory, of	fice	2	81. Location (S City or Tow	Street and Numbern, State)	er or Rura	l Route Number,
	To the Hospital within 24 hours a for the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	rsician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at to vestigation, in	he time, date an my opinion, dea	d place, a th occurre	and due to the o	cause(s) and mai date and place, a	nner as stand due to	ated. the cause(s)
)	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	maskat		29c. Li	cense number	2		29d. Date signed	(Month, I	2004
(	(4)		30. Name and address of person who o		em 23a) (Type,	Print)	het c	11000		10000	0	2004 ND 20910
	Sta Registr	_	31. Date filed (Month, Day, Year)  APR 2. 7 2004	32. Registrar's Sig		<u> </u>	31, 31	IVER	SKKIN	G. IVIA	KYLA	VD 20910

			- For	State of Ma		artment of He				1510
			State Registrar		Ce	rtificate of D	eath	Reg. N	2004	15428
	Dhysisi		1. Decedent's Name (First, Middle, La					Date of Death	ay Year	3. Time of Death
	Physici /Medio		lhomas	Goodr	nam		l A	Pril 2		7:45 PM
1	Examir		4a. Fecility Name (If not institution, gire			4b. City, Town, or Lo	ocation of Death	40	. County of Death	·
			Clinton Nursing R		er	Clinto		Pı	rince Geo	rge's
ł	Funeral Director		225-74-1459	Sex 7. Age 15 M 2□ F 52	(In yrs. last birthday) Yrs.		f Under 24 Hrs. 8. C Hours Min. Ju	Pate of Birth Month, Day, Year 11 13, 19	) Cour	olace (Stete or Foreign htry) inia
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				0d. Inside City Limits
	Aaryl F sho	ō	MD Prince G	eorge's	Cheltenha					T√□Yes 2 □ No
	28a-	Director	10e. Street and Number			10f. Zip Code		100 C	itizen of What Cour	11.
	With Sa or	ā	10505 Jib Court			20623			S.A.	itty :
	ms 2	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S. 13.		anic Origin? (Specify		14. Race - Americ	ean Indian.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ODCe.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 X	0	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No :	Mexican, Puerto Ricar Specity:	n, etc.)	Specify: Blad	etc.
Ō	2 ho	Completed	15. Decedent's E		16a. Dece	dent's Usual Occupation	on , , , ,	16b. F	(ind of Business/Ind	
21,5	thin 7	ple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5-	(Give	kind of work done duri DO NOT use retired)	ing most of working			•
2	gien.	Con	12th		' Phon	e Technicia	an	Pr	ivate	
nd	al Hy	Be (	17. Father's Name (First, Middle, Last	y		18	3. Mother's Name (Firs	st, Middle, Meider	Sumame)	
<u>Va</u>	Ment Ment	10	Gilbert R. Goo	dman			Revera A	. Wilson		
ar	2 she and ls m		19a. Informant's Name/Relationship (			ng Address (Street and				Code)
≥,′	is 1 and 2. If Health ar item 27 is		Tonnette Goodman	- Wife		Jib Court		am, Mary	land 206	523
Ore	ges 1 If ite or ott		20a. Method of Disposition 1 Buriai 2 ☐ Cremation 3 ☐	☐Removal from State	1	matory or other place)	Date		ocation - City or To	wn, State
Ë	ment mant: jury		* 4 □ Donation 5 □ Other (Special	(y)		Mem Gardens			olf, Mary	
Baltimore, Maryland 21215-0036	Departiment Departiment Important Im		21. Signature of Juneral Service Lice	uneral S Washingt	ervices, on, DC 2	inc. 20002				
	2.4		23a. Part 1 Enter the disease, or conshock, or heart failure. List only	plications that caused to one cause on each line	he death. Do not ent	er the mode of dying, s				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ney with Ex			q	Onset and Death
	/Medical		resulting in death)		consequence of):		100110110	cabcabi		
	Examiner		Sequentially list conditions,	b						
	D =	Exan iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
	te be executed ysician and e burial-transit	can	Cause (Disease or injury that initiated events resulting in death) Last	C.						
760,	cian curial		Tooland in Journal of Last	Due to (or as a	consequence of):					
687	cate I	dicai		_ d						
9 ×	The law requires that the death certificate be execued ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE:	23c. If yes, outcome o	f programme.					
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of delive Month	ry Day Year
P.O.	he de	ysic	1 Yes 2 No	4☐ Pregnant at ti 9☐ Unknown	me or death 5	Other (specify)				,
مز	res that the de signed by the a be detached f	H.	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying cause given i	n Part I. 2	3e. Did tobacco :	use contribute to th	e cause of death?
gp	uires sign d be	d by			J	, , , , , , , , , , , , , , , , , , , ,				ably 4 🗹 Unknown
Ö	w require been sig	Completed								
Ř	has ge 2	шb					2	4a. Was an autopsy performed?	prior to con death?	ssy findings available apletion of cause of
a	ician: The l certificate ha		Of Management and the medical					Yes 2 No		2 🗆 No
Division of Vital Records,	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		0.1	S. Place of Death (Che			
ō	Phy r this ral d	-	27. Manper of Death	28a. Date of Injury	t 2 ER/Outpatien	I SIJ DOA	4 Nursing Home !	5 🔲 Residence Pescribe how injui		)
o	ding F th. After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Yeer) Injury	Work?	2 □No	rescribe now injur	y occurred	
ISI	l or Attending Physician: after death. Director: After this certifics in by the funeral director, g	Certification:	3 ☐ Suicide 6 ☐ Could not b	B 200 Bloom of Jaive	y - At home, farm, str			ocation (Street an	d Number or Rural	Route Number
	5 # E C	erti	4  Homicide determined	building, etc.	(Specify)			ity or Town, State		ricoto resintosi,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	nysician: To the best of miner: On the basis of e and manner state	ixamination and/or inv	n occurred at the time, crestigation, in my opinio	date and place, and du on, death occurred at t	ue to the cause(s) the time, date and	and manner as sta place, and due to	ated. the cause(s)
	o the	Me	29b. Signature and title of certifier	Constitution State		29c. License nu	ımber	29d. Dat	te signed (Month, D	Dav. Year)
	⊢ ≯ ⊢ ŏ		· Rm	/ Om		_	1520	1	-26-0	
2	2		30. Name and address of person who	completed cause of de-	ith (Itam 22a) (Time-					
-	(5)		Bahram Pishdad,				m#310 Wach	ington	DC 2003	2
	Sta	e	31. Date filed (Month, Day, Year)	2. Registrar		,	THE TOTAL MAIN		2000	
	Registra		APR 2 7 2004		K have					

	•	For State Registrar	Please			nd / Dep	i <b>delible inl</b> artment of <i>rtificate o</i> i	Health	and M	lental Hyg	iene	2001	+ 15429
		Hegistrar     Decedent's Name (First	st. Middle, L	ast)			ranoato o	Dout	· ·	2. Date of Deat	eg. No. th	•	3. Time of Death
Physicia /Medica	ıl .		Jev	ælT. G			45 City Taylor		- of D	Month	23,	2004	8:15 A M
Examine	r	4a. Fecility Name (If not in 9209 3rd )			mber)		4b. City, Town,	or Location Janhan				County of Dea	
		5. Social Security Number		Sex	7. Age (In yrs	. last birthday	If Under 1 Yea		er 24 Hrs.	8. Date of Birth			eorge's
Funeral Director		578-54-0729 Usual Residence of Dece	9	1 ☐ M 2XIF	80		Months Day		Min.	8. Date of Birth (Month, Day, Oct 6,	Year) 192	( C	chington DC
land			County		10c. C	ity, Town or L	ocation	-				<del>-</del>	10d. Inside City Limits
-fah fied	ğ	Maryland I	rince	George	's			Lanha	am				1 XYes 2 □ No
r 28a	ec Lec	10e. Street and Number					10f. Zip Code			1	0g. Citi	izen of What C	ountry?
23e o	Funeral Directo	9209 3rd 8	Street				2	0706				US	A
deat	ner	11. Marital Status		12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of	Hispanic C	Origin? (Spe	cify Yes or No-		14. Race - Am Black, Whi	
or It	F	1 Never Married		1 ☐ Yes tf Yes, Gi	2 No		1 ☐ Yes 2 🛣 No					Specify	
ural'.	d by	3 ØWidowed 4 □ 0		Year or D						T.		BI	ack
"nat	Completed		Decedent's E by highest g	ducation rade completed)		(Give	dent's Usual Occi kind of work don DO NOT use retir	e during me	ost of workin	ng	16b. Ki	ind of Business	vindustry
withii ene. then	Ĕ	Elementary/Secondary	(0-12)	College (	1-4or 5+) 2+	,,,,,	Homemak					Priva	+0
filed Hygi other		17. Father's Name (First,	Middle, Las				110111011	7	ther's Name	(First, Middle, M	Maiden		.ce
ental ked c	To Be	Nathanie]	L Hill	.s					Lill	ian Ligh	htfo	oot	
shou nd M mar umet	-	19a. Informant's Name/F				19b. Maili	ng Address (Stree	et and Num					Zip Code)
alth a 27 is		Belita Will	Loughb	y (Daugl	nter)	9209	3rd Str	eet,	Lanha	m MD 20'	706		
item item		20a. Method of Disposition		75		Place of Dispo	osition (Name of matory or other pl	ace)	D	ate	20c. Lo	cation - City or	Town, State
Page nent c int: If iry or		1 □ Burial 2 🖾 Cre 1 □ Donation 5 □					ke Crema		4/24,	/2004	Bel	Ltsville	e, MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28a-f ahow any injury or other traumatic event, the Madical Examinar must be natified at once.	Ì	21. Signature of Juneral	Service Lice	90S00		2	2. Name and Add	ress of Fac	ility Ren	don/Hale	ר Fr	meral	Home
89 5 2 9		17/11/1	ms	900	y I		9013 Ann	apoli					
Physician	ľ	23a. Parl 1. Enter the dis lock, or heart failu Immediate Cause (Final disease or condition	ease, or cor ure. List on	y ne cause on e	caused the dea each line. Eumonia		ter the mode of dy	ring, such a	as cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	(		(or as a conse nentia	quence of):							
	je.	Sequentially list condition if any, leading to immedicause. Enter Underlying	ns, ate	b	(or as a conse	quence of):							
re be executed ysician and burial-transit	Examiner	that initiated events	1	c									
e exe ian ar urial-t		resulting in death) Last	1	Due to	(or as a conse	quence of):							
ate b hysic the bu	lical		•	d									
entific ding p	ĕ	IF FEMALE:		220 16 400 04									
leath certificate tattending physi	Physician/Medi	23b. Was decedent preg		1 ☐ Live b	tcome of pregn pirth 2 ☐ Feta nant at time of c	aldeath 3	Ectopic pregnan Other (specify)	су			2	23d. Date of de Month	livery Day Year
the d	ysi	1 ∐ Yes 2 <b>∑</b> No 9		9□ Unkn									
ires that the de signed by the a d be detached t	ρχ	Part II. Other significant	conditions	contributing to d	eath but not re	sulting in the u	inderlying cause g	iven in Par	t I.				o the cause of death?
w requir	etec											T	
The law	Completed			· · · · · · · · · · · · · · · · · · ·						24a. Was ar autops perform 1 Yes 2	y ned?	prior to death?	utopsy findings available completion of cause of
ien: artifica ctor, I	Be	25. Was case referred to examiner?	medical				17	26. Pla	ce of Death	(Check only one			
hysic his ce	0	1 ☐ Yes 2 🔀 No		Hospital: 1	Inpatient 2	1	IL 3LIDOA		Nursing Hon	ne 5 <b>½</b> Reside	nce 6	Other (Spe	cify)
nding P ath. r: After ti e funera		27. Manner of Death 1 ☑ Natural 5 ☐ 2 ☐ Accident	Pending investigation		of Injury th, Day Year)	28b. Time o Injury	W	uryat ork? ]Yes 2[		8d. Describe ho	w intury	y occurred	
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physochpletely filled in by the funeral director, page 2 should be detached for use as the	Certification:	3 Suicide 6 4 Homicide	Could not determined	28e. Place	of Injury - At hing, etc. (Speci		reet, factory, office		2	8f. Location (Str City or Town			ural Route Number,
e Hospit 1 24 hour e Funere letely fille	edicai	29a. Certifier 1X (Check only one)	Certifying P Vedical Exa	ıminer: On the b	best of my knows asis of examinations and stated.	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date a opinion, de	and place, a eath occurre	and due to the ca	iuse(s) ate and	and manner as place, and due	s stated. to the cause(s)
To th	Me	29b. Signature and little of	of certifier				29c. Licer	ise numbei	r	29	d. Date	e signed (Mont	h, Day, Year)
(18)		1		1			D	04588	1	A	pri	1 23, 2	2004
1980		30. Name and address of Carl Johns	11				Print) e Lane, l	Jpper	Marlk				
Stat Registra		APR 2 6 200	y, Year)		tegistrar's Sign	ature	•						

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

,			1 - For Registrar	State of N		epartment Certificate		and Mental	Hygien	2001	151.20
3	Physici	_	Decedent's Name (First, Middle, La					2. Date of Month	f Death	Day Yeer	3. Time of Death
	/Medio Examir		David N. Han  4a. Facility Name (If not institution, give		-syntal	4b. City, 1	Fown, or Location	1.7		c. County of Deeth	eozes
	Funeral Director		5. Social Security Number 6. S 577-64-4227 Usual Residence of Decedent	ex 7./ ☑M 2☐F	Age (In yrs. last birti 55	nday) If Under Months Months	1 Year If India Days Hours		f Birth b, <i>Day</i> , Yea 18, 1		lece (State or Foreign try)  h., DC
	Maryland a-f show	ctor	10a. State 10b. County  DC		10c. City, Town		ashingt	on		11	0d. Inside City Limits 1X Yes 2 □ No
	ath with the 23a or 28	rai Director	10e. Street and Number  4411 - 5th St.,	N.W.		10f. Zip	20	011		Citizen of What Coun United S	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, It a Modical Examination to other traumatic.	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Tyes 25 if Yes, Give Year or Dates	s? ≹No	13. Was Deceded If Yes, special Yes 2		Origin? (Specify Yes o an, Puerto Rican, etc fy:	r No- )	14. Race - Americ Black, White, of Specify: Bla	etc.
21215-0036	e filed within 72 ho at Hygiene. I other than "natur vent, It a Moulcal	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)			Decedent's Usual (Give kind of work life. DO NOT us	k done during me e retired)		16b.	Kind of Business/Inc	
and 2	d be filed antal Hygi ced other	Be	12th 17. Father's Name (First, Middle, Last Charles Har			Maine		Engineer her's Name (First, Mi Genev		,	ment
Maryland	d 2 should b h and Ment 7 Is marked traumatic e	T <sub>0</sub>	19a. Informant's Name/Relationship (	Type, Print)	19b.			ber or Rural Route No.	ımber, City	or Town, State, Zip	Code)
altimore,	Pages 1 and 3 tent of Health int: If Item 27 iny or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from Stat	e cemetery	Disposition (Namer, crematory or oti	e of her place)	Date	20c.	Location - City or To-	
Baltir	permit. F Departme Importar eny injur		21. Signal are of Funeral Service Licer		TIL		Address of Fac	4/21/2004 Stewar  Rd., N.E	t Fun	Clinton, eral Home h., DC 2	0019
8760,	Physician /Medical Examiner parial-transit	al Examiner	23a. Part ( anter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or a	line.	tre Con		es cardiac or respirato		45 each	Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		e of pregnancy 2  ☐ Fetal death at time of death	3 □Ectopic pre 5 □ Other (spe				23d. Date of deliver	y Day Year
	w requires that I been signed by should be deta	ρ	Part II. Other significant conditions of	ontributing to death	but not resulting in	the underlying ca	use given in Pari			use contribute to the	
al Reco	: The law requicate has been page 2 should	Completed						a	Vas an utopsy erformed? es 2 ☑ N	prior to com death?	sy findings available ipletion of cause of
Division of Vital Records,	Attending Physician: The r death. sctor: After this certificate his cottificate his y the funeral director, page	tlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Mann 1 Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpa			Other		lesidence	6 ☐Other (Specify, ury occurred	
Divisi	in Dir	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	9 28e. Place of li	njury - At home, farr etc. <i>(Specify)</i>			28f. Locatio	on (Street a Town, Stat	and Number or Rural te)	Route Number,
	To the Hospital within 24 hours a vithin 24 hours a completely filled	Medical (	(Check only 2 Madical Exar	ysician: To the bes ninar: On the basis and manner s	of examination and	or investigation, i	n my opinion, de	and place, and due to eath occurred at the ti	ne, date ar	nd place, and due to	the cause(s)
	To with	2	29b. Signature and title of certifier  Alvodor	Blast-	4.30		License number			ate signed (Month, D	
3	20		30. Name and address of person who SALVA-UN SYLV	<i>—</i>	death (Item 23a) (T	ype, Print) Tal	Drove,	Cherry	Mes	ry IANd	,
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 2004	32. Regis	trar's Signature			//		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** 03:45 A JoAnn S. Hill 04<u> 26</u> 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville MOntgomery Casey House 8. Date of Birth (Month, Day, Year) 01 02 38 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 13 TF Director 66 Washington, D.C <u>578-52-1660</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28e-f show event, the Medical Examiner must be notified at D.C. Washington tX∑Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1406 Delafield Place N.W. 20011 or Itams 23a USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Children's Hospital Nurse 4 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Is marked of Pagas 1 and 2 should ba Harold L. Scott Dora Henderson other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other treu once. 1406 Delafield Pl. N.W. Washington, D.C. 2001 ce of Disposition (Name of Date 20c. Location - City or Town, State Joseph F. Hill, Husband 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Rock Creek 5-3-04 Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MArshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 mars 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Hepatic Cirrhosis Pnysician 6 months. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be exacuted burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ŏ Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes X☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No or Attending Physicien: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence MOther (Specify) Hospice Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 √Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director 6 Could not be 3 TSuicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD. Charles Harrison 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 9 2004 Registrar

DHMH 17 Rev 1/2001

Oann

			For State Registrar	State of Maryland / Depa	artment of Health and I	Mental Hygien		
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year April 26, 2004 5:20 A					
100	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death 4c. County of Death			
			Layhill Center		Silver Spring Montgomery			
1 14	Funeral Director		242-14-4820	ex ☐XM 2☐F  7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Year	9. Birthplece (State or Foreign Country) 919North Carolina	
	and w	by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits	
	Maryl f sho		D.C.	Washington	n, D.C.		1 X Yes 2 ☐ No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any figury or other traumatic event, the Medical Exertinal rules the notified at Once.		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?				itizen of What Country?	
36			6537 North Capital	L Street, NE	20012	U	.S.A.	
			11. Marital Status   X   Never Married   2   Married   3   Widowed   4   Divorced	Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 1 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black	
႙								
212	hin 72 In "na Media	Completed	(Specify only highest gra	College (1-4or 5+) (Give life.	kind of work done during most of wo DO NOT use retired)	rking		
21	giene giene er the	Com	12	Cle			S. Government	
nd	d oth	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	n Sumame)	
Z	12 should h and Men 7 is marke traumatic		Mark Harvey	Time Oriest 10h Marili	Martna  ng Address (Street and Number or Ri	Arrington	or Town State Zin Code	
Maryland 21215-0036			19a. Informant's Name/Relationship (Cleora Knight-Sist	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	N. Capital St., N	•		
ē,	Heali tem 2 other		20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State					
ē	Pages ent of nt: If i		Commetery, crematory or other place)  **Description of Description of Description State    **A Donation 5 Dother (Specify)    Ouantico National     Ouanti					
Baltimore,	1 yan a Den					uneral Home		
×	<b>%</b>		23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.				or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition	Dementia a.				
			resulting in death)	Due to (or as a consequence of):				
4			Sequentially list conditions, if any, leading to immediate	b. Parkinson's Disease Due to (or as a consequence of):				
	d d ansit	min.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
Ó.	exection and and rial-tra	Ical Examiner	resulting in death) Last	Due to (or as a consequence of):				
760,	te be executed ysicien and ne burial-transit			d				
99	ng ph as th	Medi	IF FEMALE:					
.O. Box	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
σ		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Tyes 2 No 3 Probably 4 Unknown					
Ö		etec				24a. Was an	24b. Were autopsy findings available	
Records		Completed				autopsy performed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
on of Vital		Be	25. Was case referred to medical 26. Place of Death (Check only one)					
		Medical Certification: To	1 Yes 2X No 27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at		fome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred		
			1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Ďaý Year) Injury Work?  M 1 ☐ Yes 2 ☐ No  8 28e. Place of Injury - At home, farm, street, factory, office 28f. Lo				
Division			3 Suicide 6 Could not b			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	ne Hospital 1.24 hours a ne Funerel I		29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	To the within 2 To the comple		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)					
D38262				Apri	11 27, 2004			
)	(5)		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)			
				a, M.D. 2401 Resear	ch Blvd., #330, E	Rockville, N	ID 20850	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	K.			

			1 - For State Ragistrar	State of Maryla		artment of I		•	giene Reg. No. 2 (	004 15433
	Physici	an	1. Decedent's Name (First, Middle,	·			-	2. Date of De	ath Day	3. Time of Death
	/Medic		James		Henson	r		April 2	22, 20	04   8:30 A M
4	Examir	er	4a. Facility Name (If not institution, g				or Location of Dear		4c. County	
			2504 Ramb1ewood  5. Social Security Number 6		rs. last birthday)	Distric	t Height		Prin	ce Georges  9. Birthplace (State or Foreign
	Funeral Director		324-14-4938	1⊠M 2□F 87		Months Days	Hours Min	(Month, Da	th y, Year) 4,1917	Country) Illinois
			Usual Residence of Decedent					i acre cir	,1)1/	IIIIIII
	how		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	e Ma	cto	Maryland Prince	e Georges   D	istrict	Heights	3			1 No 2 No
	ith th	Dire	10e. Street and Number	_		10f. Zip Code			10g. Citizen of V	What Country?
	s 23s	by Funeral Director	2504 Ramblewood		110	20747			USA	A section to the
	ter de Item	n.	11. Marital Status  1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces?	WWIT 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	specify Yes or No to Rican, etc.)	Blac	e - American Indian, ck, White, etc.
336	irs af	by	3 ☐ Widowed 4 ☐ Divorced	1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 ☑ No	Specify:		Specify	«White
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Exurili rar must be notified at	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	usiness/Industry
215	within 7 ene. than "n	ple	(Specify only highest (Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of wo d)	rking		
	filed withi Hygiene. other then	Completed		2	Budge	et/Financ				Government
<u>n</u>	be fill stal H od oth	Be	17. Father's Name (First, Middle, La					me (First, Middle,	Maiden Suman	ne)
7	should be filed within 72 hours after dea nd Mental Hygiene. s marked other then "natural", or Items umatic event, the Medical Exuminar in	2	Ear1  19a. Informant's Name/Relationship		nson	A 11	Lola	15-1-1	- O' - T	Dorriss
Maryland	P P P	1	Anita L. Henson			Ramb Lawa			·	, MD 20747
_	1 and 3 Health tem 27	1 7	20a. Method of Disposition	·		esition (Name of matory or other pla		Distict		City or Town, State
Baltimore	8 2 = 5		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Premoval nom State			1	( 10 1	01.	1/17)
Ħ	permit. Pa Departmer Important: any injury		21. Signature Juneral Service Lig			cion Ceme  2. Name and Addre			Clinton	n, MD
B	permit. Departr Importa any inji		> 1/2 11. 10	uler	Ge	2. Name and Addre Porge P. 160 Oxon	Kalas Fu	neral Ho	me, P.A	20745
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the d	eath. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	124 Dist T	1135	Coció	(0)	THE F	WW	A Onet and Death
	/Medical		resulting in death)	Due to (or as a cons	sequence of):	45011	13 00	114	15100	11 100010113
	Examiner		Sequentially list conditions	CANCER	OF	7745	BU	HAPEN		1 YEAR
	.p	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
	rate be executed obly sician and the burial-transit	cam	that initiated events resulting in death) Last	c Due to (or as a cons	namena of					
8760,	be ex cian buria	al E		Due to (or as a cons	sequence or).					
687	physicate sthe	dlc		d			945-45-33			
Box (	leath certifica attending ph I for use as th	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-	gnancy				23d Dat	e of delivery
B	death a atter d for u	clar	in the past 12 months?	1□Live birth 2□F 4□Pregnant at time o		Ectopic pregnancy Other (specify)	y		Moi	.,
P.O.	that the de sed by the a detached f	hys	9 Unknown	9□ Unknown					1	
	law requires that the death centificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions	- · ·		111		23e. Did to	obacco use conti	ribute to the cause of death?
ord	w require been signal	ted	ARTEKIOS	CLENEXIC	Cotal)	10 VASO	UGAL D	TYTE	res 2 No	3 Probably 4 Unknown
Records,	has be	Completed						24a. Was autop	an 24b. V	Vere autopsy findings available prior to completion of cause of
<u> </u>	The ate h page	Corr						perfo 1 ☐ Yes	rmed2 c	leath? □Yes 2□No
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?		-			ath (Check only o	ne)_	
of	Physic this c	2	1 Yes 2 No		ER/Outpatier		4   Nulsing r	ome 5 Resid		
n C	Jing Ph	ion	27. Manner of Death 1 Salatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Wor	ryat rk? Yes 2 ⊟No	28d. Describe	now injury occurr	ed
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	ospital hours uneral ly filled		29a. Certifier 1 Certifying	Physician: To the best of my l	knowledge, deatl	occurred at the tir	me, date and place	and due to the	cause(s) and ma	nner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Ex	aminer: On the basis of exam and manner stated.	ination and/or in	vestigation, in my o	pinion, death occu	irred at the time,	date and place, a	and due to the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier			29c. Licens	e number		10.	(Month, Day, Year)
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) /	(1)			no completed cause of death (I						
_(	· 0/		Philip Wisotsky			Center	# 207 Wa	ldorf, M	aryland	20602
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State of Maryland / Department of Health and Mental Hygiene 2001 15636 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yeer **Physician** April 21, 2004 7:00 a Herman Ly1e Hanna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 96 577-03-2108 April 12, 1908 New York Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23s or 28s-f shov other traumatic event, the Michael Examinar must be inclined at 1 Yes 2 No Prince George's Greenbelt Maryland Directo 10g, Citizen of What Country? 10e Street and Number 10f Zin Code 8673 Greenbelt Road, Apt. 102 20770 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1925— Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates: þ White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Motor Mechanic U.S. Government Pages 1 and 2 should be filed nent of Health and Mental Hygi int: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be David A. Hanna Mildred Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy A. Hammond - Grandson 70 Frazer Road, Garrison, NY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Fort Lincoln Cemetery 04/26/2004 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee Darock Zawing 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS tmmediate Cause (Final disease or condition Days **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Days PNEUMUNIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consultience of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No detached tor 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown LZUEIMOAS DIJEASE Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2 🗆 No After this certificate 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide To the Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)018 APRIL 23 2004 who completed cause of death (Item 23a) (Type, Print) A. DEVORE MD 4203 Weensbury Rd Myster 1/2 MD 20781 IVA 31. Date filed (Month, Day, Year) APR 2 6 2004 32. Registrar's Signature Registrar

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	an	1. Decedent's Name (First, Middle Charles	Edward		Harmon	2. Date of Dea Month	Day Yee <b>9 20</b> 0	3. Time of Death 6.30 A
Medic camin	CI -	4a. Facility Name (If not institution			4b. City, Town, or Location of Dec		4c. County of De	
KEIMIIA	er	10541 Flower St			Berlin		Word	ester
neral		5. Social Security Number		. last birthday)	If Under 1 Year If Under 24 Hr Months Days Hours Mil	n. (Month, Da	h (Year) 47 9.8	irthplace (State or Fore Country)
ctor		216 - 44-8429 Usuel Residence of Decedent	13 M 2 L F	<b>₹</b> 57 Yrs.		March :		aryland
		10a. State 10b. County	10c. C	ity, Town or Lo	cation	-		10d. Inside City Limi
	Director	Maryland Worce	ster	Berlin				1 ☐ Yes 2 ☐ X
		10e. Street and Number			10f. Zip Code		10g. Citizen of What to USA	Country?
	Funerai	10541 Flower St	12. Was Decedent Ever in U	J.S. 13.1	21811 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-		nerican Indian,
	þ	1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	erto Rican, etc.)		nite, etc. Black
	eted	15. Decedent (Specify only highes	's Education	(Give	dent's Usual Occupation kind of work done during most of w	rorking	16b. Kind of Busines	ss/Industry
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	oo Not use retired) employed		Autobody	and Repair
		17. Father's Name (First, Middle,	ast)	Jen .		ame (First, Middle,		una nopan
	To Be	Brazille Briddell				Maree Ha		
	-	19a. Informant's Name/Relations	nip (Type, Print)	19b. Mailir	ng Address (Street and Number or I	Rural Route Numbe	r, City or Town, State	, Zip Code)
		Tammy Harmon			Box 108 - Berlin			Chata
ė		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demousi from State	cemetery, crer	sition (Name of natory or other place)	Date	20c. Location - City	
		4 □ Donation 5 □ Other (S)  21. Sign three of Funeral Service			Church Cem. 04/			
ouce		21. Signature of Funeral Service	conses Allo	11			y Moad D	
20		23a. Part1. Enter the disease, or	complication, that caused the de-	ith. Do not ent	olley Memorial Ch er the mode of dying, such as cardi	ac or respiratory ar	rest,	21801 Approximate Interval Between
ın		Immediate Cause (Final	Gastroin					Onset and Death  2 week
al er		disease or condition resulting in death)	Du to (or as a conse		a victoria			
		Sequentially list conditions,	b. Duodena		cinoma			10 month
	Examiner	Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (brise a corise	quanta oty:				
	xan	that initiated events resulting in death) Last	C. Due to (or as a conse	quence of):				
	cai		d					
	Medi	IF FEMALE:						
	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)		23d. Date of o Month	lelivery Day Year
	도	Part II. Other significant condition	ns contributing to death but not re	sulting in the u	nderlying cause given in Part I	23e. Did to	bacco use contribute	to the cause of death?
	a.				nderlying cause given in rait i.		′es 2 No 3□	Probably 4 Unknow
	by				noonying occording to an in-	101		
	by				restrying sauss given in a tr.	24a. Was		
	by				noonymig occoso given mit ann.	24a. Was		o completion of cause of
	Completed by	25. Was case referred to medical			26. Place of D	24a. Was autop perfo	sy prior to death' 2 No 1 Y	o completion of cause of
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	To Be Completed by	examiner? 1   Yes 2   No  27. Manner of Death 1   Vatural 5   Pendin	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	26. Place of D  tt 3 DOA Other: 4 Nursing  f 28c. Injury at Work?	24a. Was autop performed to the control of the cont	sy prior to death' 1 Young)	o completion of cause of
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	To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death 1 Matural 5 Pendin 2 Accident investig	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	26. Place of D  at 3 DOA Other: 4 Nursing  28c. Injury at Work?  M 1 Yes 2 No	24a. Was autor performed autor	sy prior to death 1   Y    ne)	o completion of cause of pas 2 MNo
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		_	For State Registrer	State of Marylan	_	artment of F			Reg. No. 20	04 <u>15437</u>
	Physicia /Medic	al	Decedent's Name (First, Middle, Last)     Grace Elizabe     4a. Facility Name (If not institution, give state)	eth Hamstr	a	4h City Town o	or Location of Dea		_	7:05 PM M
	Examin Funeral Director		1137 Riverside I 5. Social Security Number 6. Seo 350-07-2632 1□	rive	last birthday) Yrs.	Salish If Under 1 Year Months Days	ury	8. Date of Birt	Wicon	
	e Maryland Sa-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomic		y, Town or Lo lisbur					10d. Inside City Limits 1 🛣Yes 2 □ No
	ath with the 23a or 21	ral Directo	10e. Street and Number 1137 Riverside Dri	ve			21801		10g. Citizen of Wh	
036	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. All Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, I're Medical Examinar must be notified at event, I're Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 H No	dispanic Origin? (9 an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Race - Black, Specify:	American Indian, White, etc. White
21215-0036	within 72 ho iene. 'than "natur	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired NESS Mana	during most of wo d)	orking	16b. Kind of Busi	ness/Industry ent Banking
73	should be filed and Mental Hygis s marked other umatic event, tr	To Be Co	17. Father's Name (First, Middle, Last)	letz	DUDII	icos rand			Maiden Sumame)	
J.	ss 1 and 2 of Health of item 27 li other tra		19a. Informant's Name/Relationship (Ty  J. Howard Hamstra  20a. Method of Disposition  1 □ Burial 2 🎖 Cremation 3 □ R	(husband)	1137 lace of Dispo emetery, crer	Riversi esition (Name of matory or other place	de Drive	, Salisb Date	ar, City or Town, St UCV Mar 20c. Location - C	yland 21801 ty or Town, State
Baltimore,	permit. Page Department of Important: If any njury or once.		1. Signature of Fundral Service Censury.  21. Signature of Fundral Service Censury.	De la companya della companya della companya de la companya della	Ho 50	Ol Snow H	ss of Facility Funeral H Fill Road	ome Prof , Salisb	essional ury, Mar	
	ate be executed  Wedical Wedical We buriat-transit	Ical Examiner	a3a. Pán11. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a consequ	uence of):	meet Fou	June .	c or respiratory ar	rest,	Approximate Interval Between Onset and Death MIN'S
.O. Box 68	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy	,		23d. Date of Month	
Records, P.	w requires that been signed to should be deta	by	Part II. Other significant conditions cor AOKTIC STENOSIS	stributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
		e Completed	25. Was case referred to medical				26 Place of Do	24a. Was autop perfor 1 Yes	rmed? dea 2 1 No 1	re autopsy findings available or to completion of cause of the cause o
οţ	ling Physici.  After this cer uneral direc	ToB	avaminar?	ospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	er: 4 ☐ Nursing H	lome 5 Desid	fence 6 □Other	
Division	2 th th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	′)			City or Tow	m, State)	or Rural Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical	(Check only 2 Medicel Examinate)	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or in	occurred at the tirvestigation, in my o	pinion, death occi	urred at the time, o	date and place, and	d due to the cause(s)
5			29b. Signature and title of certifier  30. Name and address of person who co	moleted cause of death (from	23a) (Type				29d. Date signed (	Juy Tear)
	Sta Registr	_	Jumble Mark Par Year)  31. Date filed (Month, Day, Year)  APR 2 3 2	MD 467 32. Registrar's Signal	Ecizler ture	Print) W Shree	Spring	, Sali	buy,	hu 21804

RJ

	1 - For State Registrar	State of Marylan		artment of He rtificate of D			ene 1. No.2 0 0	4 15438
Physician	Decedent's Name (First, Middle,     Rodger Darnel					2. Date of Death Month April 25	Day Ye	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, University - Sh	give street and number)	er	4b. City, Town, or L	ocation of Death		4c. County of D	
Funeral Director	157-68-6045	6. Sex 7. Age (In yrs. 1	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. 971 N	Birthplace (State or Foreig Country) ew Jersey
Maryland fishow	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltime		ty, Town or Lo	cation imore				10d. Inside City Limits 1X Yes 2 □ No
with the Mar s or 28e-f s be rediffed Director	10e. Street and Number		Daic	10f. Zip Code		100	. Citizen of What	
2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland le marked other then "naturel", or items 23e or 28e-1 show reumatic event, the Mastical Examinat must be incliffed at To Be Completed by Funeral Director	218 South Pays	12. Was Decedent Ever in U Armed Forces?		208 Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2√2 No		pecify Yes or No- Pican, etc.)	14. Race - A	merican Indian, hite, etc.
d 2 should be filed within 72 hours all the and Mantal Hygiens 71 emarked other then "naturel; or treumatic event, the Madical Exami To Be Completed by F			(Give	dent's Usual Occupat kind of work done du DO NOT use retired) klifter	ion uring most of wor	king	Sb. Kind of Busine	ŕ
wild be filed Mental Hygi arked other artic event, To Be Cc	17. Father's Name (First, Middle, Li Eric Asbey Jenk					e Johnson		
and 2 sho saith and N n 27 ie ma	19a. Informant's Name/Relationshi Tamelle Louise	Jenkins/ Wife	9706 Lank	ng Address (Street ar 5 Locust A 13m, Maryl	venue	706		
permit. Pages 1 and 2 should Departit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic. 2006.	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	3 □Removal from State Conscity) Lo	cemetery, crer rraine	sition (Name of natory or other place) Park Cem.	05-0	01-04 1		e, Maryland
permit. Departimental imports any injure.	21. Signature of Funeral Service Li  Wanda C  23a. Part1. Enter the disease, or c	Bacon, CC 36	/ 34	447 14th S	St., N.W.	. Wash., 1	D.C. 200	Home, Inc. 10 Approximate
tificate be executed by popular as the burial-transit as the dical Examiner		a.  Due to (or as a consect b.  Due to (or as a consect c.  Due to (or as a consect d.	quence of):	ch ly;	ives			
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sicien: The law requires that the de certificate has been signed by the a rector, page 2 should be detached to Be Completed by Physic	Part II. Other significant condition	s contributing to death but not res	sulting in the u	nderlying cause giver	n in Part I.			e to the cause of death?  Probably 4 □Unknow
ician: The law requir certificate has been s' rector, page 2 should							prior death	autopsy findings availal to completion of cause of ? es 2 \sum No
Hospital or Attending Physical Anous after death.  Funerel Director: After this lely filled in by the funeral dicition of the		28a. Date of Injury (Month, Day Year)	fy) owledge, deat	at 3 DOA  Cher  28c. Injury: Work: M 1 You eet, factory, office	4 Nursing H	28d. Describe how  28f. Location (Streen City or Town)  and due to the cau.	et and Number or State)	Rural Route Number, as stated. tue to the cause(s)
To the within 2 To the complet	29b. Signature and liftle of certifier  30. Name and address of person w  THEODORE M	U King us	720\/Time	29c. License O. C. M			Date signed (M. April 2	

State of Maryland / Department of Health and Mental Hygiene	2	0	0	4	5	
Certificate of Death					-	

			State Registrar  1. Decedent's Name (First, Middle,	Last)		Ce	rtificate of	Death	2.	Date of Dea		V	3. Time of Death
	sicia ledic		THOMAS	ODELL	JC	OHNSO	N, JR.		A	Month PRIL	2 <sup>Day</sup> , 20	04	11:15a M
į.	mine		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	or Location of	Death		4c. County	of Death	
			Hospice of Ch	esapeake			Linthi	cum			Anne	Δτιι	ndle
Fune	eral				ge (In yrs. la	st birthday)	If Under 1 Year Months Days		Min. 8.	Date of Birth (Month, Day			place (State or Foreign
Direc			237-44-4349 Usual Residence of Decedent	14S M 2 F	70	Yrs.	Mortins Days	riours	1	0-09	-1933	CHAR	LOTTE, NC
death with the Maryland ims 23a or 28a-f show	=		10a. State 10b. County		10c. City,	, Town or Lo	ocation					1	IOd. Inside City Limits
e Ma		Director	DC		Wa	shin	gton						1∏Yes 2☐No XX
th th	3	l'e	10e. Street and Number				10f. Zip Code			1	log. Citizen of	What Cour	ntry?
th wi	9		5217 Central	Ave SE			20019				USA		
dea		Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Decedent of I	lispanic Origi an. Mexican.	in? (Specify	Yes or No-	14. Rac	e - Americk, White,	can Indian,
15, with young 15, 15, 15, 15, 15, 15, 15, 15, 15, 15,	T T T T T T T T T T T T T T T T T T T	۵	1 ☐ Never Married 2 ☐ Marrie 3 🏋 Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 If Yes, Give Year or Dates:	No	1	1 ☐ Yes 2X No			,,	Specif		ACK
72 hours aff	GICBI	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most	of working		16b. Kind of B	usiness/în	dustry
e filed within al Hygiene other than	8	d E	Elementary/Secondary (0-12)	College (1-4or	5+)								
led wi	8		12	Lath.		Gro	cery Cl		de Maria //	Adiadata	Giar		
y latter build be fill Mental Hy arked oth		Be	17. Father's Name (First, Middle, Li						•		Maiden Suman	18)	
ould Men Marke	SEE C	ှ	Thomas Odel		on S	r		Mayo			eland		
d 2 should be th and Mental	une.		19a. Informant's Name/Relationshi				ng Address (Street				-		
1 and Health	190		Curtis Johnso	on, son	ant Di		5 Muske						
P of H	6		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Pla	metery, crea	sition (Name of matory or other pla	ce)	Date		20c. Location -	City or To	own, State
Pag ment	à l		* 4 ☐ Donation 5 ☐ Other (Spe	cify)	Har	mony	Cemete:	ry 5	-1-04	4 <u>L</u>	andove	er, l	Иd
permit. Pages 1 an Department of Heal Important: If Item 2	eny in		21. Signature of Funeral Service of	ensee			2. Name and Addre		D.F.				AL SERVIC
10			23a. Part1. Enter the disease, or c shock, or heart failure. List of	producations that ceused	d the death.							AUIII	Approximate
Physic	ion		Immediate Cause (Final	_									Interval Between Onset and Death
/Medi			disease or condition resulting in death)	a. Head 8 Due to (or as			ncer						
Exami		ì		Due to (or as	a conseque	erice or):							
	20	-	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a conseque	ence of):							
<b>B</b>	USII	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
executed in and	al-ua	Xa	that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):					-		
certificate be	eu s	Medical		_ d.									
certii	280		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	ncy					23d Da	te of delive	201
es that the death cerigned by the attendir	101	Physician/	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3[	Ectopic pregnancy Other (specify)	У				nth	Day Year
the d	Deug	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown									
that the	deta		Part II. Other significant condition	s contributing to death b	out not resul	Iting in the u	nderlying cause giv	en in Part I.		23e. Did tol	bacco use cont	nbute to th	ne cause of death?
requires een sign		p								1 🗆 Ye	es 2 🗆 No	3 Prob	ably 4 QUnknown
	nous	mpleted					·		_	-			
a s	N	du								24a. Was a autops	SV	prior to con	psy findings available mpletion of cause of
afe ∃	Da	ဂ် ပ								perform		death?	2 No
icien: Th	director,	Be	25. Was case referred to medical examiner?	11:					of Death (C	heck only on	10)		
- × ×	al dir	2	1 ☐ Yes 2KNo	Hospital: 1 Inpatie			t 3 DOA	4 🗆 14013	sing Home	5 Reside	ence <b>5X</b> Oth	er (Specif	Mospice
	non.	0	27. Manner of Death 1XX atural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	28c. Injui Wor	y at rk?	28d.	Describe ho	ow injury occur	red	
Attending ar death.	1001	cat	2 Accident investiga 3 Suicide 6 Could no				M 1 🗆	Yes 2 □ N	lo				
or Att	o o	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad   288. Place of In	jury - At hor Ic. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f.	Location (SI City or Town	treet and Numb n, State)	er or Rura	l Route Number,
ital c	De	ပါ											
To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A	etely III	edical	29a. Certifier Check only one) 2 Medical E	Physician: To the best ceminer: On the basis of and manner st	of examination	rledge, deati on and/or in	n occurred at the til vestigation, in my o	me, date and opinion, death	place, and h occurred a	due to the catter the time, d	ause(s) and <i>ma</i> ate and place,	inner as st and due to	ated. the cause(s)
To the Within	dwo	Me	29b. Signature and title of certifier				29c. Licens	se number		2	9d. Date signe	d (Month,	Day, Year)
H,\$H	0		- hardin	D. West	m		D23	743			4-23-		
(1		-	30. Name and address of person w	no completed cause of a	death (Item	23a) (Tune	Print)						
UP				D O E3	CD 7	525 (	Print) Greenway	, Cont	ter D	r #20	)5 Gre	enhe	20770 15 Md
9	Stat	e	Martin Weltz 31 Date filed (Month, Day, Year)	D. O. F'A  32. Registr	rar's Signatu	ure C	T. CELLMY)	Cent	CCI D	- π20	J GIE		
Re	gistra		APR 2 6 2004	Chan 14	de	de							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland /	•	artmen rtificate			nd M		Reg. No	20	04	1544
	Physici /Medic Examir	al	Decedent's Name (First, Middle, L     CHARLES     4a. Facility Name (If not institution, g.)	DWARD I	PILGRIM		JUPIT		Location of	Death	2. Date of Do Month APRI	L 2	3, 2	Year 2004 of Death	3. Time of Death 3:00 p
	Funeral Director	CI	HOLY CROSS H	OSPITAL	ge (In yrs. last i	birthday) Yrs.		SILV	ER SPE	RING	8. Date of Bi (Month, D. April	and les	TOM	GOME	CRY ace (State or Forei lry) 1yana
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or Itams 23a or 28a-f show event, the Medical Examiner court be notified at	Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Md. Mont  10e. Street and Number  10951 Amherst  11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced  15. Decedent's (Specify only highest g  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las	12. Was Decedent Armed Forces' 1	? <b>(N</b> )0	13. )	Was Deced if Yes, spec 1 ☐ Yes 2 dent's Usua kind of wor	Code  lent of Hinty Cubar  Cocupa  k done de retired)	Specify: tion turing most o	in? (Spe Puerto F	cify Yes or No lican, etc.)	10g. Cit	izen of WiniteContents  14. Race Black Specify: ind of Bus  Der	hat Count d Sta - America , White, & Bla miness/Ind	od. Inside City Limit  1  Yes 2 N  Ity?  Ites  an Indian,  Ick  ustry
Baltimore, Maryla	permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If item 27 is marked c enty injury or other traumatic evento.	To	Eleazer Jupite  19a. Informant's Name/Relationship  Michael Jupiter  20a. Method of Disposition  1 Burnal 2 December (Special Control of Contro	(Type, Print)  / Son  □Removal from State (fy)	20b. Place ceme Ches	0945 of Dispo tery, cren apea	Amhe sition (Nam natory or of ke Cr	rst in the of the of place emated Address	Ave.	When the distribution of t	pitol	Md. 20c. Lc Bo	2090 cation - C	)2 hty or Tov ville , Inc	wn, State
8760,	death certificate be executed  By attending physicien and and are transit of for use as the burial-transit	dical Examiner	23a. Pary. Enter the disease, or do shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. VENTE  Due to (or as  b. Due to (or as  c.	d the death. Dine.  RICULAR  a consequence a consequence a consequence	ARR) se of):			, such as ca	ardiac or	respiratory a	irrest,			Approximate Interval Between Onset and Death
.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pre Other (spe					4	23d. Date Monti		y Day Year
Records, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions HYPERTENSION		out not resulting	g in the ur	nderlying ca	iuse give	n in Part I.						cause of death?
al Rec	The ate	Completed	ALZHEIMER'S	DISEASE						_	24a. Was autor perfo 1 Yes	psy irmed?	pri	ere autop or to com ath? Yes 2	sy findings available pletion of cause of
Division of Vital	I or Attending Physician: "after death. Director: After this certifical in by the funeral director, p	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 Xeo  27. Manner of Death  1 Xeatural 5 Pending investigate 2 Accident investigate 3 Suicide 6 Could not determined	28e. Place of In	ury 28b uy Year)	. Time of Injury	M 28	A Other  Bc. Injury Work'  1   Y	r: 4 🗆 Nurs	eing Hom 21	e 5 Resident	dence 6 how injury	y occurred	d 	Route Number,
7	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical Ce	29a. Certifier (Check only one)  1 Certifying P 2 Medical Example of certifier	hysician: To the best miner: On the basis of and manner st	of examination a	ige, death and/or inv	estigation,	t the time in my opi	number	place, ar	nd due to the d at the time,	date and 29d. Date	and mann place, and e signed (	d due to t	ay, Year)
2	Sta Registr	DOM:	30. Name and address of person who Shashank Patel, 31. Date filed (Month, Day, Year)  APR 3 0 200	M.D. Regist	death (Item 23a 2309 She rar's Signature	oref:	Print)			eato	n, Md.		902	-4,	2004

		1	1 - For State Registrar	State of Marylan		artment of H			ene 20	04	15441
	Physici		Decedent's Name (First, Middle, Last)     Edith Jones Jo					2. Date of Death Month April	Day	Year 004	3. Time of Death
· (5)	/Medio Examir		4a. Facility Name (If not institution, give s Prince George s	street and number) Hospital			Cheverly	h	4c. County Pri	of Deeth	George's
	Funeral Director	250	225-46-5529	14 0X =	6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1937	Coun	elece (State or Foreign etry) ginia
	e Maryland a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  DC	10c. Cit	y, Town or Lo		ington			1	0d. Inside City Limits 1   Yes 2  No
	with the	Director	10e. Street and Number	C. C.E. #2	03	10f. Zip Code	20019	10	g. Citizen of V		
036	should be filed within 72 hours after death with the Maryland of Mental Hyglene marked other than "natural", or liems 23e or 28e-f ehow implied event, it a Medical Eracid at malle could be coulded as	by Funeral	4204 E. Capito1  11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent Ever in U Armed Forces?  1 Yes, Sive Year or Dates:	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba 1 Yes 2X No		Specify Yes or No- to Rican, etc.)	14. Race	- Americ k, White,	tates ean Indian, etc. lack
Maryland 21215-0036	l within 72 ho jene. r than "naturi tra Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th	cation a completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	rking 1	Bureau Affair	of	
land	₽ d fa b y	To Be C	17. Father's Name (First, Middle, Last)  Thomas Emmi	tt Jones				me (First, Middle, M Edith Po	aiden Sumam		
Mary	alth and Malth a		19a. Informant's Name/Relationship (Ty, Adrienne B. Sisc	•				ural Route Number, y., #W911			
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any niury or other treumatic once.		20a. Method of Disposition    ↑ Burial 2 □ Cremation 3 □ R  ↑ 4 □ Donation 5 □ Other (Specify)			sition (Name of natory or other place emorial E			oc. Location - Lando	•	
Balti	permit. Pag Department Important: any njury o		21. Signature of Funeral Service Linense			. Name and Addres	s of Facility	Stewart Fu ., N.E. Wa			019
8760,	Physician and // / / / / / / / / / / / / / / / / /	dical Examiner	23a. Part. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to consequence).	uence of):  2	-		Hem of		2	Approximate Interval Between Onset and Death
O. Box 68/	death certifi e attending a d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive	ory Day Year
ds, P.	uires that i signed by Id be deta	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	an in Part I.	23e. Did toba	. 1		e cause of death? ably 4 ∐Unknown
Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed	Dissets	Melleter	)			24a. Was an autopsy perform	ede d	rior to cor	psy findings available inpletion of cause of
Ital		Bec	25. Was case referred to medical examiner?	9 20				ath (Check only dne			
0	ding Physia n. After this or funeral dire	은	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	ospital: 1 patient 2 2 28a. Date of Injury (Month, Day Yeer)	ER/Outpatien 28b. Time of Injury	t 3 DOA Othe 28c. Injury Work	4 ∐ Nursing F	lome 5 Residen			)
Division	tor: the	Certification:	2   \qua	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str		Yes 2 □ No	28f. Location (Stre City or Town,	et and Numbe State)	ar or Rura.	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier   12 Certifying Physics   12 Certifying	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time time time of the time of time of time of the time of time of time of the time of time	ne, date and place pinion, death occu	a, and due to the cau urred at the time, dat	use(s) and mar e and place, a	nner as st nd due to	ated. the cause(s)
7	To the H within 24 To the Fi complete	Me	29b. Signature and title of certified	al typ	_>	29c. License	number 105286		d. Date signed April	_	Day, Year)
	(6)		30. Name and address of person who co  Michael Fig.  31. Date filed (Month, Day, Year)	/	001 Ho	erint) spital Dr	., Cheve	erly, MD	20785		
	Sta	ite	ΔPR 2 R 2004	negistrar s Signa	TOLO .	•					

			1 - For Stete Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment rtificate	of H	ealth ai Death			Reg. No.	2004	10115
	Physici	an	Decedent's Name (First, Middle, Last)						2	2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medi Examir	cal	LEON 0.  4a. Facility Name (If not institution, give s GLADYS SPELLMAN S	,		4b. City, To	_	Location of		PRIL 2	4c. (	004 County of Death INCE GE	
	Funeral Director		5. Social Security Number 6. Sex 579-36-0599 Usual Residence of Decedent	7. Age (In yrs. [M 2□F 74	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	4 Hrs. 8 Min.	Date of Birt (Month, Day 11 01	192	9. Birth Cou 9 Wash	place (State or Foreign intry) ington, DC
	the Maryland 28e-f ehow	Director	10a. State 10b. County  MD Prince Ge  10e. Street and Number		ty, Town or Lo Landov		ode.				100 Citiz	en of What Cou	10d. Inside City Limits 1  Yes 2 □ No
	3a or	I DI	1500 Brightseat 1	Rd # 101			078	5			_	S.A.	intry :
9600	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel; or items 23s or 28e-f ehow other traumatic event, the Medical Execites must be recitied at	d by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔯 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 □ Yes 2 <b>2</b>	Š No	Specify:	n? (Speci Puerto Ri	fy Yes or No- can, etc.)	5	4. Race - Ameri Black, White, Specify: B1	ack
21215-0036	filed within 72 Hyglene. other then "nat	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 11th		(Give	dent's Usual kind of work DO NOT use lice C	done du retired)	uring most o	of working			d of Business/Ir vernmen	
Maryland 2	2 should be filed and Mental Hygi is marked other aurmatic event, II	To Be Co	17. Father's Name (First, Middle, Last)	on Sr.						First, Middle,	Maiden S		
	Health and 2 sho			/ Sister	8502	Magno	lia		Lan	ham, M	ary1	Town, State, Zij and 207	06
Baltimore,	9 5 = 5		20a. Method of Disposition  1 ⊠ Burial 2 ☐ Cremation 3 ☐ Ro  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cren armony	natory or oth	er place,	·	Dat 5/4/2			ation - City or To over, Ma	
Bai	permit. Pag Department Importent::1 eny injury o		21. Signature of Funeral Service Cense	6	74		ndov	er Ro	ad L	andove	r, Ma	Funer aryland	al Home 20785
8760,	Physician /Medical Examiner the prize of the	Ical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uenca of):								Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	i death 3	Ectopic preg					23	d. Date of delive	ery Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	iderlying cau	se given	in Part I.					he cause of death?
of Vital Records,	The law requir ate has been si page 2 should	Completed	Carcinsna laa.	·					_	24a. Was a autops perform	ned?	prior to co death?	psy findings available mpletion of cause of
f Vita	nysician: nis certific director,	To Be C	25. Was case referred to medical examiner?	ospital:	ER/Outpatient	3□ DOA				Chack only on	ė)	□Other (Specif	
Division o	ling After uner	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	Mork?	at es 2⊡No	280	f. Describe ho	ow injury	occurred	
Divi	P Sign		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	v) 					City or Town	7, State)		il Route Number,
	To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only one)  1 ☑ Certifying Phys 2 ☐ Medical Examin 29b. Signature and title of certifier	icien: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death tion and/or inv	estigation, in	the time my opir	nion, death	occurred	at the time, d	ate and p	lace, and due to	the cause(s)
)	T M P S		Paule	inlev.	re co	1 1			52			signed (Month,	
	6		30. Name and address of person who cor Paul Devor 3001 H				207	85					
	Sta Registr		31. Date filed (Month, Day, Year)  ADD 9 8 7104	lospital Dr 2. Registrar's Signa	ture	1							

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 4 Decedent's Name (First, Middle, Last) 2. Date of Death Day Month laria Johnson 8:00 pm 2002 4a. Facility Name of not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Thomas Moore Nursing Home 5. Social Security Number 6. Sex 7. Age (In yr. Hyattsville If Under 1 Year | If Under 24 Hrs. | 8. Months | Days | Hours | Min. | 8. Prince Georges 6. Sex 1 □ M 2X F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 84 Yrs. 578-46-7296 Dec. 25,1919 | South Carolina 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits YE Yes 2 No D.C. Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 909 Lawrence St., N.E. U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) lyr Pratical Nurse Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Elisha Croker Annie Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas F. Johnson/Husband 909 Lawrence St., N.E. Wash. D.C. 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cem. 22. Name and Address of Facility 4/20/04 Silver Spring, Md. 21. Signature of Funeral Service Licensee Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCILROTIC HEART DISTASE Due to (or as a consequence of): Due to (or as a consequence of). Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? DIABETES MEULTUS, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

The law requires that the death certificate be executed

**Physician** /Medical

Examiner

Be Completed by

**Physician** 

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show enty injury or other traumatic event, the Macifical Examiner must be notified at once.

Baltimore, Maryland 2

/Medical

Director

Funeral

Completed by

Be

ds, P.O. Box 68760, Division of Vital after death.

Director: After din by the fundament To the Hospitai or Atter within 24 hours after der To the Funeral Director completely filled in by th

State Registrar

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. HIPORTENSION END STAGE KENAL DISTASE CORONARY ARTRY DISTASE PERPETERAN VASUALAR DISTASE 1 - Yes 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as steted.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and due to the cause(s) and manner as steted.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as steted. Medical

lean of the Surto mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Doris Bustos 1160 Varnum St. NE #213 Wash., DC 20017

31. Date filed (Month, Day, Year)

APR 2 7 2004

Registrer's Signature

S			1 - For State Registrar	State of Ma	aryland / Depa	artment of F		-	giene Reg. No. 2004	151.1.1.
		٣	Decedent's Name (First, Middle, La.	st)				2. Date of De	ath	3. Time of Death
	Physici: /Medic		Harold	l Bernard	Jordan			Month April	Day Year 15 2004	750 a M
	Examin		4a. Facility Name (If not institution, give	e street and number)			r Location of Death		4c. County of Dea	
			931 Amer Drive		- // to at high to )	If Under 1 Year	ashington			e Georges
	Funeral Director		5. Social Security Number 6. S 577–60–9191	MEX 2□F 7.Ag	e (In yrs. last birthday) 57 Yrs.	Months Days	Hours Min.	(Month Da	$(v, y_{\text{ear}})$ 1946 $(v, y_{\text{ear}})$ 1946 Wasi	thplace (State or Foreign buntry) nington, D.C.
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	oation				10d. Inside City Limits
	lanyla shov	'n		Georges			<b>n</b>			1 X Yes 2 □ No
	the N 28a-1	rect	10e. Street and Number	Georges	FOIL	Vashingto	ш		10g. Citizen of What Co	ountry?
	3a or	i Di	931 Amer Drive			20744			United Sta	•
	death	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No	14. Race - Ame Black, Whit	
36	72 hours after death with the Maryland natural", or Items 23a or 28a-f show Jical Examiraer must be notified at		1 Never Married 2 Married			Yes 2X No	Specify:	1110011, 010.7	Specify: B	•
Ö	hours tural	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ec		June 1969	dent's Usual Occup	ation		16b. Kind of Business	**************************************
5	n "na	piet	(Specify only highest gra	ide completed)	(Give	kind of work done of DO NOT use retired	during most of work	king		of Columbia
21215-0036	filed within Hygiene. other then "	Completed by	Elementary/Secondary (0-12) 12th grade	College (1-4or 5		REMAN			Fire Depa	
Maryland	ev d al	Be	17. Father's Name (First, Middle, Last)  Cushman Jo:						Maiden Sumame)	
ıryla	s 1 and 2 should be I Haalih and Mental Item 27 Is marked o other traumatic eve	2	19a. Informant's Name/Relationship	rdan Type, Print)	19b. Mailir	na Address (Street	Hele		etcher or, City or Town, State, 2	Zip Code)
	요독 <b>2 :</b>		Alfred Fletcher J							
Baltimore,	0 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo			Date 1 26,200	20c. Location - City or	Town, State
<u><u>E</u></u>	Pages ment of ant: If it ury or o		`4 □Donation 5 □Other (Specif		Maryland		am Veter	ans Ceme	tery; Mar	yland
3alt	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service Licer	iseer (	MAA T	Name and Addre	ss of Facility Compa	ny Mort	icians, Inc	
	707 e 0		23a. Part1. Enter the disease, or com			000 Kenne	dy Street	,N.W.;W	ashington,I	Approximate
>	Physician /Medical Examiner	er	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Cutes Due to (or as	a consequence of):	4 Vous	of the	el		Interval Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0						
o,	icate be exacuted physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
68760,	ate be hysici the bu	edicai	•	, d						
O. Box (	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
0	res that the de signad by the a be detachad t	by Ph	Part II. Other significant conditions of	ontributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord	w require been sig should b							1 □ Y	′es 2□No 3□Pr	obably 4 Unknown
Records,	e law r has be je 2 sh	Completed						24a. Was autop	sv   prior to a	topsy findings available completion of cause of
al F								perfor 12 Yes	med? death? 2□No 1□Xes	2 No
Vital	sician: certific irector,	o Be	25. Was case referred to medical examiner? 1 □XYes 2 □ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatier	nt 3□ DOA Oth	er:			at agono
o	ig Phys ter this neral di		27. Manner of Death	28a. Date of Inju (Month, Da					ence 6 <b>X</b> Other (Specow injury occurred	city) at scene
ion	ittending l death. ctor: After / the funer	atio	1 □Natural 5 □ Pending 2 □ Accident investigation	Fred 4/151		YYM 1□		Subje	t shat self	/
Division	or Attending Physician: ifter death. Director: After this certific in by the funeral director,	Certification:	3 <del>Su</del> icide 6 □ Could not be 4 □ Homicide determined	e 28e. Place of Inj building, et	ury · At home, farm, str c. (Specify)	e, factory, office		28f. Location (S City or Tow	treet and Number or L n. State)	er Prive
Ω	Hospital of the Hospital of Hours af Funeral D Fulled Itely filled Itely		20 C 4 C 4 C 4 C 4 C 4 C 4 C 4 C 4 C 4 C	-1-1 T. N. t	home			fort Work	try grand	u l
	Hos 24 ho Fune etely f	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Examone)	niner: On the basis of and manner sta	f examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the e red at the time, o	ause(s) and manner as date and place, and due	stated. to the cause(s)
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	4 3		29c. License	e number	- 2	29d. Date signed (Monti	n, Day, Year)
	15		1 Theolos	26 16	& mad	000	ME		April 16,	2004
	(1,0		30. Name and address of person who	completed cause of	with (Item 231) (Type,		0:			1 0.555
	36		THEODORE MIK		ndo Circon	111 Pe	enn Stree	t, Balti	more, Mary	Land 21201
	Sta	te :	3 Par filed (Month Out 4 Year)	32. Redistr	ars S mature					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2004 **Physician** April 19 3:35 P M MILDRED KIRKSEY /Medical 4a. Fecility Neme (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Larkin Chase Nursing Home Prince George's Bowie If Under 1 Year | ff Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🕏 F Yrs. 76 578-44-5422 Director July 26 1927 South Carolina Usuel Residence of Decedent the Maryland 10c. City. Town or Location. 10a, State 10b. County 10d. fnside City Limits or 28a-f show Examiner must be notified at MD Prince George's Bowie 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20720 U.S.A. "natural", or items 23a 11215 Maiden Drive death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Baltimore, Maryland 21215-0036

mit. Pages 1 and 2 should be filed within 72 hours after cognition of thealth and Mental Hygiene.

Indication: If item 27 is marked other than "natural", or item only injury or other traumatic event, the Medical Examinations injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married 1 Yes 2 No **Black** þ Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 Yrs Elementary/Secondary (0-12) Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred Brown Inez Wilson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11215 Maiden Drive Bowie, Maryland 20720 Daphne VanBuren/Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 4/24/2004 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 la noha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a vicindiac or respiratory arrest, shock, or heart failure. List only one cause in each line. fmmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 4 Dinknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Certification: To 1 Yes 2 No 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After fnjury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospitel or Attence within 24 hours after death To the Funerel Director... the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ò 4 Homicide 🐰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of artifier 29c. License number 29d. Date signed (Month, Day, Year) 3 D57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A itya Chopra M.D. 600 Ridgley Avenue # 231 Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 6 2004 Registrar

		State of Maryland / Dep 1- State Registrar AMEND IIEM #24a PER PHY C831 5/13/04	artment of Health and		ene g. No. 200	14 15448
Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
/Medic Examin	al	Geraldine Iouise Keller  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deal	Horil	4c. County of	1 2110 PM
Examin	eı	Washington County Hospital	Hagerstown		,	gton County
Funeral Director		5. Social Security Number 220–28–7889 6. Sex 1. Age (In yrs. last birthday, 1. M 2X F 71 Yrs.		. (Month, Day,	Year) 9	Birthplace (State or Foreign Country)  Maryland
land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
the Marylar 28a-f show	ctor	Maryland Washington Hagerst	OWTO.			XXYes 2 □ No
with th	<b>Funeral Director</b>	10e. Street and Number	10f. Zip Code	10	g. Citizen of Wha	at Country?
ier death w	eral	49 Fairground Ave.  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21740 Was Decedent of Hispanic Origin? (5	Specify Ves or No.	U.S.A.	American Indian,
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland Healin and Mental Hygiene. The Paris and Mental Hygiene. Other traumatic event, the Madical Examinat must be notified at	by	1 Never Married 2 Married 1	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 X No Specify:	to Rican, etc.)		White, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft tin and Menlal Hygiens 77 is marked other than "natural", or traumatic event, the Medical Exami	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking	6b. Kind of Busin	ness/Industry
212 ad with giene or tha	Com	10 Dy	e Machine Operato	or	Ribbon M	Mfg. Co.
Maryland 2121. 2 should be filed within in and Mantal Hygiens file marked other than 'reumatic event, tre Mer	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	
aryla should I	2	Russell Keller  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	Ing Address (Street and Number or Ri	homas Kel		
Mand 2 s aith an 27 is ritrau			Fairground Ave. H		•	
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 271 any injury or other tre once.		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition competery, cre	osition (Name of matory or other place)		Oc. Location - Cit	
Balti permit. Departmimporta any inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Do	uglas A. 1	Fiery Fu	meral Home
876( cate be physicia the bur	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	1331 Eastern Blvd ter the mode of dying, such as cardial Fig. Curclio vo.	or respiratory arres	it,	Approximate interval Between Onset and Death
Box 6 death certification of attending of for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)	Yes	23d. Date of Month	f delivery Day Year
cords, p.0	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			te to the cause of death?
as b	Completed			24a. Was an autopsy performe	24b. Were prior deat	e autopsy findings available to completion of cause of h?
r Wrtal R	Bec	25. Was case referred to medical examiner?	26. Place of Dea	1 ☐ Yes <b>※</b> ath <i>Check only one</i>	No 1 □	Yes 2 No
On O' On O' Jing Ph After th	2	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Processing Services (Month, Day Year)  Hospital: 1 Inpatient FR/Outpatien 2 Sex. Date of Injury (Month, Day Year) 2 Reproductive Services (Month, Day Year) 2 Reproductive Services (Month, Day Year) 2 Reproductive Services (Month, Day Year)		ome 5 Residence 28d. Describe how		Specify)
DIVIS	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	et and Number o State)	r Rural Route Number,
Hospi 4 hou Funer ely fill	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deatled the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manne and place, and	r as stated. due to the cause(s)
	Ž	29b. Signature and title of certifier  Reugen J. Hoef.	29c. License number D 28365	29d	Date signed (M	lonth, Day, Year)
3H-2		30. Name and address of person who completed cause I death (Item 23a) (Type, TAN2AN. TSHAR 368 M	Print) Print) Print) Print)	genstown	219D.	21740
Stat Registra		31. Date filed (Month, Day, Year) APR 19 2004 32. Registrar's Signature	-Ke	()	<u> </u>	

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

APR 28 2004

100 C. 32. Registrar's Signature 29c. License number

125209

29d. Date signed (Month, Day, Year)

SAlisbury Md 21801

April 26, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 04 20 2004 8:35 JOSEPH STATEN LITTLETON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11358 SHARPTOWN ROAD MARDELA SPRINGS WICOMICO 6 Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1**X** M 2 □ F 05-01-1934 WILLARDS, MD. 69 Director 218-30-2205 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo MD WICOMICO MARDELA SPRINGS 10g. Citizen of What Country? 10e. Street and Number 11358 SHARPTOWN ROAD 21837 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 ☐ No !f Yes, Give **Items** filed within 72 hours after 1 ☐ Never Married 2X Married ō 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Year or Dates "naturs!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR HIGHWAY DEPARTMENT 12 othar nd 2 should be filed lith and Mental Hygi 27 Is marked other r traumatic svent. 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUFUS LITTLETON MAUDE BAKER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is sny injury or other trau QRCs. SHIRLEY LITTLETON - SPOUSE 11358 SHARPTOWN ROAD MARDELA SPRINGS, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 04-22-2004 DELMAR, DELAWARE ⁴ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature & Funeral Service Licer 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a construence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last halle Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. 3 Probably 4 Unknown 1XYes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hrvylamias page 2 autopsy performed? 1 Tes 2 No 1 Yes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М hours after death unerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) within 2. and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of berson who completed ause of death (Item 23a) (Type, Print) de De Biox Stuber pd. 21801 560 32 Registrar's Signature Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of		Reg. No. 2004 15151
Physician /Medical	1. Decedent's Name (First, Middle, Last, Percy Wise Law	son		2. Date of I Month April	Dey Year 15 2004 5:00AM
Examiner	4a Fecility Name (If not institution, give		1	4b. City, Town, or Location of De	
	Mariner Health			Bethesda	Montgomery
Funeral Director	5. Social Security Number 6. Sec. 125 125 125 125 125 125 125 125 125 125	7. Age (In yrs. I	ast birthday) If Under 1 Year Months Days	Hours Min. 8. Date of E (Month, III) NOV •	9. Birthplace (State or Foreign Country) 13, 1935 Wash., DC
show of all	10a. Stete 10b. County	10c. City	r, Town or Location		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
he M	DC 100 Street and Number			ington	
with t	10e. Street end Number	. A N. II	10f. Zip Code	20005	10g. Citizen of What Country?
s 23	1314 Massachuset	12. Was Decedent Ever in U.		20005	United States  14. Race American Indian,
Baltimore, Maryland 21215-0020  permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mental Hygiene.  Deperment of Health and Mental Hygiene.  Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mant be notified at pace.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:	13. Was Decedent of h	lispanic Origin? (Specify Yes or I an, Mexican, Puerto Rican, etc.) Specify:	Black, White, etc.  Specify: Black
Maryland 21215-0020 d 2 should be filed within 72 hours eff th and Marial Hygiens of 1s marked other than "natural", or traumatic event, the Medical Exercit To Be Completed by F	15. Decedent's Edu (Specify only highest grede Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16e. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	i)	16b. Kind of Business/Industry
Son Con	12th		Reside	nt Manager	Private
Be doth	17. Father's Neme (First, Middle, Last)			18. Mother's Name (First, Midd	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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re, Maryla s 1 and 2 should t Health and Man tan 27 ts marks other traumatic	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing Address (Street	and Number or Rurel Route Num	nber, City or Town, State, Zip Code)
e, P	Johnniteen Oate 20a. Method of Disposition	s - Friend	#1 Morning ace of Disposition (Name of	ngside Ct., Sil	ver Spring, MD 20904
Baltimore, semit. Peges 1 er Pepes 1 er Pepes 1 er mportant: If Itam 2 my Injury or other since.	1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	0.0	Glenwood Ceme:	ce)	
Balt permit. Depent Import any inj	21. Signature of Funeral Service License	to 7.11	22. Name and Addres	ss of Facility Stewart ning Rd., N.E.	Funeral Home Wash., DC 20019
	23a. Part 1 Enter the disease, or complishock, or heart failure. List only or	cations that caused the death			
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		JNG CAN		Onset and Death
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Box 68760, eath certificate be as eltending physician a lifer use as the burial clar/Medical E)	that initiated events resulting in death) Last		as a consequence of):		
Geath death of for	Part II. Other significant conditions con	tributing to death but not resul	Iting in the underlying cause give	en in Part I 23b Dia	d tobacco use contribute to the cause of death?
Is, P.O. Box es that the death certiqued by the ettendin be deteched for use by Physician/N					Yes 2,27No 3 Probably 4 Unknown
aw requires been s 2 should pleted				24a. Wa	s an autopsy formed? 24b. Were autopsy findings available prior to completion of cause of death?
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f Vital I ysician: The ysician: The scarificate director, page	25. Was case referred to medical examiner?	o on ital.		26. Place of Death (Check only	
n of mg Phys ter this uneral d	27. Manner of Death  1 Natural 5 Pending	1	ER/Outpatient 3 DOA Other  28b. Time of Injury 28c. Injury Work	/ at 28d. Describe	sidence 6 Other (Specify) how injury occurred
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he Hospita in 24 hours he Funeral pletely fille	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	Ician: To the best of my know er: On the basis of examination	ledge, deeth occurred at the timon and/or investigation, in my of	ne, date and place, and due to the pinion, death occurred at the time	e cause(s) and manner as stated. o, date and place, and due to the cause(s)
Me Me	29b. Signature and title of certifier	0	29c. License	number	29d. Date signed (Month, Dey, Year)
	1 Truo	ysas,	mo Do	057124	4/19/04
DCC.	30. Neme and eddress of person who con Truon Bao,			Cerrace, German	town, MD
State Registrar	31, Dete filed (Month, Dey, Yeer) APR 2 6 2004	32. Registrer's Signatu			

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LAWSON, DERCY

		ı		Department of Health and Certificate of Death		2001 151.50
100	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Li Ying Fan Lee  4a. Facility Name (If not institution, give street and number)  University of Maryland Medical System	4b. City, Town, or Location of D  Baltinic		Yeer 200 A M  County of Death  altimore City
	Funeral Director		5. Social Security Number 6. Sex 1 M 2/F 7. Age (In yrs. last bit	rthday) If Under 1 Year If Under 24 I	Hrs. 8. Date of Birth Min. (Month, Day, Yeer)	
	e Maryland Be-f ehow	Director		or Location South Pasadena		10d. Inside City Limits 1 ⊠ Yes 2 □ No
	th with the 23a or 2	al Dire	1630- Bank Street	10f. Zip Code 91030		tizen of What Country? Taiwan
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ten 27 ie marked other than "natural", or itams 23a or 28e-f ehow amyr injury or other traumatic event, the Medical Examerantal be notified at ance.	by Funeral	11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Marned If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Chinese
Maryland 21215-0036	Jwithin 72 ho jiene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation     (Give kind of work done during most of life. DO NOT use retired)     Homemaker	working	At Home
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	1d 2 should lith and Men 27 le marke r traumatic			b. Mailing Address (Street and Number of 0709-Boswell La.		
Baltimore,	Peges 1 ar		cemete	of Disposition (Name of ory, crematory or other place) awn Cemetery 5/		ocation - City or Town, State
Bait	permit. Peges Department of the Important: If the any injury or of once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hysong Co.	,Inc.	
>	Physician /Medical	9)	23a. Part. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)		diac or respiratory arrest,	Approximate Interval Between Onset and Death
¥	Examiner	_	Sequentially list conditions, if any leading to immediate	avanoma		7 months
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P.O. Box 68	O O	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)	4	23d. Date of delivery Month Day Year
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Division of Vital Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vit.	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ⋈ No Hospital: 1 ☑ Inpatient 2 □ EP/O	Othor	Death (Check only one)  ng Home 5 Residence	6 ∏Other (Specify)
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Divis	s after de	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge of the control one of the certifying Physician: To the best of my knowledge of the certifier of the certifie	e, death occurred at the time, date and pl nd/or investigation, in my opinion, death o	lace, and due to the cause(s occurred at the time, date and	) and manner as stated. d place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number P1767a		ite signed (Month, Day, Year)
12	(2)		30. Name and address of person who completed cause of death (Item 23a) E Fontanilla 22 S Greene	St Bultimore 1	Maryland 21	1201
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ORIGINAL

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			1 - For State Registrar		State of	iviaiyiaii		tificate		ilth and M eath		giene Reg. No. 2	004	15453
	Ohoria		1. Decedent's Nam	ne (First, Middle	e, Last)						2. Date of De	ath		3. Time of Death
	Physic /Medi		Maria	G.	Lemus						Month APRIL	24, 20	У <sup>еаг</sup> 004	4:12 P M
	Exami		4a. Facility Name (	(If not institution	, give street and numb	ber)		4b. City, To	own, or Loc	ation of Death			nty of Death	
					L CENTER			BAL	TIMOF	E CITY				
	Funeral		5. Social Security N		6. Sex 7.	. Age (In yrs 35	• •	If Under 1 Months		Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthp Coun	ace (State or Foreign try)
	Director		212-61-9 Usual Residence of	-, -			Yrs.				06-11-	1968	E1 Sa	lvador
	land ow		10a. State	10b. County		10c. City	y, Town or Lo	cation					11	Od. Inside City Limits
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	filed within 72 hours after death with the Maryland Hygiene. Ither then "natural", or Items 23e or 28e-f show ent, the Medical Exama and usal to molilled at	Completed by Funeral Director	11. Marital Status		12. Was Deced	ent Ever in U.	S. 13. V			nic Origin? (Spe exican, Puerto	cify Yes or No	14. R	ace - Americ	an Indian,
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Maryland 21215-0036	should be nd Mental marked c	2	19a. Informant's N	lame/Relationsh	nin /Tyne Print)		10h Mailin	a Address /6				. Oit T-	- 01-1- 7	0-4-1
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5	Pages nent of h int: If ite		1 🛣 Burial 2 ` 4 □ Donation		3 ☐Removal from Sta		emetery, crem e of H			04-2	9-04	Silver	,	
Baltimore,	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan D. p. trment of Health and Mental Hygiene. D. p. trment of Health and Mental Hygiene. In portant: If item 27 is marked other then "natural; or Items 23a or 28a-1 showen injury or other traumatic event, the Medical Exament or other traumatic event, the Medical Exament or other traumatic event, the Medical Exament or other traumatic event, the Medical Exament or other traumatic event, the Medical Exament or other traumatic event, the Medical Exament or other traumatic events.	9 6	21. Signature of Fu							Facility W • II				
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			23a. Part1. Enter t	the disease, or	complications that cau			er the mode of	of dying, su	ch as cardiac o	r respiratory ar	rest,		Approximate
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7	/Medical		resulting in death)		a. Due to (or	as a consequ	uence of):	(01	1174	C/4 17 0	W 3			
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Ξ		o Be	examiner?		Hospital:	-tit 0 -	-D/O-1		Other	Place of Death			-	
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Division	Attending or death. sctor: After by the fune	ifica	3 Suicide	6 Could no	ot be 28e. Place of	Injury - At hor	ne, farm, stre	et, factory, of			8f. Location (S	reet and Num	ber or Rural .	Route Number,
Ö	alor s afte il Dire	Certification:	4 🗍 Homicide		building,	etc. (Specify,	)				City or Town	n, State)		,
	ospit hours unere		29a. Certifier	1 Certifying	Physician: To the be	st of my know	vledge, death	occurred at t	he time, da	ite and place, a	nd due to the ca	ause(s) and m	anner as sta	ed.
	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	edical	(Check only one)	2X wedicar E	xaminer: On the basis and manner	s of examinati stated.	on and/or inve	estigation, in	my opinion	, death occurre	d at the time, d	ate and place	, and due to t	he cause(s)
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R	(4)		30. Name and addr	ess of person w	no completed cause of	of death (Item	23а) (Туре, Р							
1			31. Date filed (Mon	TRY C.	RIPPLE	<u>~</u>		TII I	enn S	street,	Baltim	ore, Ma	arylan	d 21201
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**ORIGINAL** 

		1 - For State Registrar	State of Ma	aryland / Depa		ealth and Me	ental Hygier	•	15455
Phys		Decedent's Name (First, Michael Control of the	ddle, Last) 1. S. LITTLE		-		2. Date of Death Month 4 21	Day Year . 2004	3. Time of Death
Exan	dical niner	4a. Fecility Name (If not institu	tion, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deeth	
			REL REGIONAL I		LAUREL			NNE ARUNI	
Funera Directo		5. Social Security Number 577–58–5909	6. Sex 7. Ag 1  M 2	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes 9 4 194	ar) Cou	place (State or Foreign intry) inia
Aaryland Fahow	ō	Usual Residence of Decedent  10a. State 10b. Cour  MD Prin	ce George's	10c. City, Town or Lo	eltsville				10d. Inside City Limits 1√2 Yes 2 ☐ No
28a-	rect	10e. Street and Number	te deolge 3	1	10f. Zip Code		10g.	Citizen of What Cou	intry?
h with		4503 Josephi	ne Avenue		2070	5		U.S.A.	
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Chartment of Health and Mental Hygiene.  Chartment of Health and Mental Hygiene and the file and t	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Nover Ma	It YAS GIVA	No I	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☑ No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Amer Black, White Specify: B	
2 hou atura	ted	15. Deced	dent's Education	16a. Dece	dent's Usual Occupa	ation		Kind of Business/Ir	ndustry
I within 72 jene. r than 'n	omple	Elementary/Secondary (0-12 12th	2) College (1-4or s	life.	kind of work done d DO NOT use retired,	during most of workin		Private	
in all y leave 2 to 2 to 2 to 2 to 2 to 2 to 2 to 2 t	To Be C	17. Father's Name (First, Midd	,			18. Mother's Name  Ivy H		len Sumame)	
nd 2 sho alth and N 27 is me		19a. Informant's Name/Relation	onship <i>(Type, Print)</i> Little/Husband			and Number or Rural ne Avenue			
rent. Pages 1 av pertment of Hea mportant: If itam iny injury or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 4 □ Donation 5 □ Other	on 3 Removal from State	20b. Place of Dispo cometery, crea	osition (Name of matory or other place Cemetery	θ) 4/26/		Location - City or T	
mporta Importa	ouce.	21. Signature of Puneral Serv		22	2. Name and Addres	J. Over Road	B. Jenki: Landover	ns Funera Maryland	1 Home d 20785
Physicia /Medica Examine	al	23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)		s Shock s a consequence of):	er the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
ate be executed ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to or as Anemia	a consequence of):					
the death certificate I the death certificate I y the attending physisched for use as the b	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive	very Day Year
S, F es that gned b be deta	þ	Part 11, Other significant cont	litions contributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	
The law req ate has beer page 2 shou	Completed						24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
sician: Th certificate irector, pag	Be	25. Was case referred to med examiner?	lical Hospital:		Othe	26. Place of Death			_
ling Physician: I. After this certific	lon: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ※ Natural 5 ☐ Per	28a. Date of Injuration	ury 28b. Time o	f 28c. Injury Work	4   Nursing Hom	ne 5 Residence 8d. Describe how in	6 Other (Speci jury occurred	ify)
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident invi	uld not be ermined 28e. Place of Injuried building, eigenstand	jury - At home, farm, str tc. (Specify)			8f. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
To the Hospital o within 24 hours af To the Funeral D completely filled in	edical C		fying Physician: To the best cal Examiner: On the basis of and manner st	of examination and/or in					
To the within To the comp	¥	29b. Signature and title of per	mm	ME MD	29c. License		210 29d.	Date signed (Month,	Day, Year)
(1)			. Azinge, M.D.	. 6201 Gree		d Suite M	-17 Colle	ge Park,	Md. 20740
	State istrar	31. Date filed (Month, Day, Ye APR 2	2004 Registr	rar's Signature	ut,				

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg	
	For	State of Maryland / Department of Health and Mental Hygiene 2	nn
-	State Registrar	Certificate of Death Reg. No.	0

			1 - State	State of M	larylan	d / Depa Ce	artment of I <i>rtificate of</i>	lealth Deatl	and M	ental Hy			4 15	456
			1. Decedent's Name (First, Midd	fle, Last)		00	Timeate of	Dean		2. Date of De			3. Time of	Death
	Physici /Medio		Annie Caroline	e Elizabeth R	obbins	Lankf	ord			Month April	Day	Year 6. 200	7:5	0a™
	Examir		4a. Fecility Name (If not institution	on, give street and number	)		4b. City, Town, o	or Location		1121		County of Dea		
			Berlin Nursing				Berlin If Under 1 Year	If I lode	or 24 Hrs.	0 D-1(Di-	41-	Worces		
	Funeral Director		5. Social Security Number 265-03-9814	1 M 2 KF	94	last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da Sept.	in 19, Ye <i>ar)</i> 22. ]	1909 Ma	rthplace (State of country) arvland	r ⊢oreign
	pu *		Usual Residence of Decedent  10a. State 10b. Count	v	10c Cit	y. Town or Lo	ocation						10d. Inside Cit	ty Limite
	Marylan f ehow	ō					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						1 🗆 Yes	-
	r 28a-f	Director	Maryland   Worce 10e. Street and Number	ester	BE	erlin	10f. Zip Code				10g. Cit	izen of What C	ountry?	
	23a or		10204 Germante	own Road			21811					USA		
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Decedent of H	dispanic C an, Mexic	rigin? (Spe an, Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Wh		
39	ges 1 end 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. It ferms 27 is marked other than "neturel", or items 23a or 28a-f ehow of their traumatic event. The Medical Examinar must be notified at or other traumatic event. The Medical Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Mar 3 🖾 Widowed 4 ☐ Divorce	If Yes Give	No		1□Yes 2ሺNo	Specif	y:			Specify: B	lack	
215-0036	72 hou	ted	15. Decede	nt's Education est grade completed)		16a. Dece	dent's Usual Occup kind of work done	pation	ast of working	ng.	16b. K	ind of Business	:/Industry	
121	within ene. than "	Completed	Elementary/Secondary (0-12)		5+)	life.	DO NOT use retire	d)	, di Workin	·y	m	-1- YT-		
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Mary	2 should be and Ment is marked aumatic		19a. Informant's Name/Relation			19b. Mailin	ng Address (Street	and Num	ber or Rural	Route Numb	er, City o	r Town, State,	Zip Code)	
J ~	ges 1 end 2 t of Health if Item 27 or other tra		Selena Purnell/s	ister	20h P		4 German			- Ber		Marylan		
Jo Se	Pages nent of h int: if Ite		1 X Burial 2 ☐ Cremation  1 4 ☐ Donation 5 ☐ Other (		3 (		esition (Name of matory or other pla nel Ch. Ce							
4	교문문문		21. Signature of Funeral Service	· · · · · · · · · · · · · · · · · · ·	1116		2. Name and Addre						2	MD
∯n _	Depar Impo		Malrice	a W. Sh	lles	1 10	LLEY ME	EMOR	IAL C	HAPEL			21801	
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 01	Codin	4 (	ance						A 1	215
	Examiner			Due to (or as	rivo U	ence of):	Vasa	les	· D	iscu	F-C			
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	иелсе of):								
	and and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequ	uence of):								
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		Medical	IF FEMALE:											
Вох	eath certif attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregnanc	y			1	23d. Date of de Month		'ear
0.	that the desed by the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant a 9⊡Unknown	at time of de	eath 5	Other (specify) _						,	
۵.	The law requires that the death certivite has been signed by the attending age 2 should be delached for use a	by Ph	Part II. Other significant condit	ions contributing to death i	but not resu	ulting in the u	nderlying cause giv	en in Part	I.	23e. Did t	obacco u	se contribute t	o the cause of de	eath?
ecords,	w require been sig should b									101	/es 2[	□No 3□P	robably VU	Inkлоwn
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	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ient 2 🗆	ER/Outpatien	it 3 DOA Oth			(Check only o		6 ☐Other (Spe	novifu)	-
Jοt		n: T	27. Manner of Death  Natural 5 ☐ Pendi	28a. Date of Inju	ury	28b. Time of				8d. Describe I			City)	
siol	Attending ir death. ector: After by the fune	catic		tigation			M 1 🗆	Yes 2						
Division	I or Atten after deatl Director:	Certification;		mined 289. Place of In	itc. (Specify	me, farm, str	eet, factory, office		2	8f. Location (S City or Tox			ural Route Numb	)er,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director:		29a. Certifier Certifyi	ing Physician: To the best	of my know	wledge, death	occurred at the tir	me, date a	nd place, a	nd due to the	cause(s)	and manner a	s stated.	
	the H the Fi	Medical	one)	I Examiner: On the basis of and manner st	tated.	ion and/or in			ath occurre					
	P P P		29b. Signature and title of certifu	Jone le	//		29c. Licens	o number	69		290. Dat	e signed (Moni	O C	
	THE		30. ame and address of person	who completed cause of	death (Item	23а) (Туре.	Print) / 3	209	10	par for	10	Feelen	No.	
	0,		Nielioles - 1	). Borod	eelia	cu	DE	w	K.	To le	d	De	1994	1
	Sta Registr		31. Date filed (Month, APR 2	3 2004 32 Regist	rar's Signa	ture &	Span	KN			,			

Registrar

			1 - For State Registrar AMPND TIMES PO	State of Maryland /	Depa Ser	rtment tificate	of H	ealth a	ınd Mer		iene eg. No.	2004	15457
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Maria	Corina		gar				Date of Deat Month pril	Day	, 2004	3. Time of Death  11:15PM
}	Examin		4a. Facility Name (If not institution, give st 27 Heritage C	ourt		An	nap	olis			Aı	ounty of Death	unde1
	Funeral Director		NONE	7. Age (In yrs. last b	Yrs.		Year Days	If Under: Hours	Min. 0 (	Date of Birth (Month, Day, Ct. 3	, 194	9. Birth Cou 40 Gua	nplace (State or Foreign untry) tamala
	Maryland f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne	Arundel	wn or Lo	cation Anna	ро1	is					10d. Inside City Limits 1 ☐ Yes 2 ☐ Xlo
	3a or 28a	Funeral Director	10e. Street and Number 27 Heritage C			10f. Zip (	Code	401		1	_	en of What Cou	-
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Itam 27 is merkad other than "natural", or Items 23a or 28a-f show or other traumatic evant, the Medical Examinational traumatic evant, the Medical Examinational traumatic evant, the Medical Examinational traumatic evant, the Medical Examinational traumatic evant, the Medical Examinational traumatic evant.	by Funera	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decede Yes, speci				y Yes or No- an, etc.)		4. Race - Amer Black, White Specify: Wh	e, etc.
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vant, I're M. ole	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give :	lent's Usual kind of work OO NOT use HOUS 6	done d retired,	u <i>ring</i> mosi )	of working			d of Business/l eone F e	
land;	should be filed nd Mental Hygi markad other imatic evant, II	To Be C	17. Father's Name (First, Middle, Last)  Juan Antonic	Melgar					r's Name <i>(F</i> 1ana	irst, Middle, I		<sub>Sumame)</sub> onzale	ez
Mary	nd 2 should alth and Men 27 ie marka ir traumatic		19a. Informant's Name/Relationship (Typ Miriam Melgar/Da			-					-	Town, State, Z ala Gu	ip Code) latemala
Baltimore,	permit. Pages 1 an Depertment of Heal Important: if Itam 2 any Injury or othar once.		20a. Method of Disposition 1	emoval from State Cuil					Date u n			ation - City or 1 tema1a	
Balti	permit. Depertm Importa any Inju		21. Signature of Funeral Service Licenses	0	1 4	. Name and 451 I	Addres Oare	s of Facilit	Sewe each	11 Fu Rd.Pr	ner inc	al Hom e Fred	ne 1.,MD20678
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Do e cause on each line.									Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	HYDERTEN	e or): /5 (				1012				
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b.	Due to (or as a consequence	e of):								
8760,	ate be executed obysician and the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a consequence	e of):								
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Δ.	g g P	by	Part II. Other significant conditions conf	tributing to death but not resulting	; in the ur	nderlying ca	iuse give	on in Part I.		23e. Did tol	_		the cause of death?
Records,	The law requires ate has been sign page 2 should be	Completed					<u>-</u> .			24a. Was a autops perform	у .	prior to c death?	topsy findings available completion of cause of
r Vital	Phyelclan: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) No	ospital: 1  Inpatient 2 ER/C	Outpatien	t 3 DO	A Othe	0.00		Check only on		□Other (Spec	afy)
ion of	ding h. After fune.	ation: T	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	. Time of Injury	M 28	3c. Injury Work 1 🗆 `	rat ⟨? Yes 2□		I. Describe ho	ow injury	occurred	
Division	D it o	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory,	office		28f	Location (Si City or Town		Number or Ru	ral Route Number,
	To the Hospital of within 24 hours a To the Funeral Completely filled in the funeral Completely fin	edical		icien: To the best of my knowled er: On the basis of examination a and manner stated.									
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	3		30. Name and address of person who con	mpleted cause of death (Item 23a	a) (Type,	Print) 344	UNI	ven:	5174	BLM	w.	51LW	EN SPRING
ľ		ate rar	31. Date filed (Month, Day, Year) APR 2 3	2 CANO, M . J 32. Registro's Signature	K	doe	Ko						-

2	- S		1 - For 4-30-04 Registrar Amerid #2.PerP		artment of Health and Natificate of Death	Re	g. No. 2001	
	Physicia	an	Decedent's Name (First, Middle, Last	,		2. Date of Death Month	Day13, Year	3. Time of Death
	/Medic	al	Laura Beatric			Apri1	<del>12</del> 2004	7:42 A M
	Examin	er	4a. Facility Name (If not institution, give Prince George'		4b. City, Town, or Location of Death		4c. County of Deat	
	9		5. Social Security Number 6. Se		Cheverly If Under 1 Year   If Under 24 Hrs.	8 Date of Birth		George's
	uneral irector		436-36-6702	M 2 <b>X</b> F 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, July 9,		nplece (State or Foreign untry) SSISSIPPI
aryland	show	_	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Le	ocation			10d. Inside City Limits
th the M.	or 28a-f e notifie	Director	Maryland Prince 10e. Street and Number	George	Largo Largo	10	g. Citizen of What Co	1 X Yes 2 No untry?
÷ ×	23a	aic	10907 Benning	ton Drive	20774		United	States
r dea	em e	Iner	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Wait	ncan Indian,
036	"natural", or Itema 23a or 28a-f show Idical Examiner must be notified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐▼No	1 ☐ Yes 2 🔀 No Specify:	,,		rican merican
T	- 40	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	le completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	6b. Kind of Business/l	ndustry
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arylan 2 should be and Mental		2	Rance Dixon			E11a	Evans	
	27 tr		19a. Informant's Name/Relationship (T) Giffred Johnson		ng Address (Street and Number or Run 907 Bennington Dr.			,,
re, N s 1 and 3 f Health	If item or other		20a. Method of Disposition			-	Oc. Location - City or	
Pages	nt: If i		1	tomoval mom otato		/2004	Davidsonv	.:11. MD
<b>Saltimore,</b> permit. Pages 1 as Department of Hea	Important: eny injury once.	1	21. Signature of Funeral Service Licens	2	2. Name and Address of Facility St 4001 Benning Ro	ewart Fu	neral Home	
			23a. Part1. Anter the disease, or comp.	lications that caused the death. Do not en				Approximate
	sician edical		shock of heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	7	OF LEG FRACTI			Interval Between Onset and Death
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cuted	nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. SIGMOID VOL	VULU5	3 h		
760, te be executed	nysician and he burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequence of):  ELECTROLYTE	DISORDER D	N. C. C. C. C. C. C. C. C. C. C. C. C. C.		
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Hecords, P.O. Box 68 The law requires that the death certifical	by the attending plached for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	very Day Year
Records, P.	signed I be de	by	Part II. Other significant conditions co.	ntributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
OS S	shouk	lete				24a, Was an	24h Word aut	opsy findings available
	cate has	Completed				autopsy performe	prior to co	ompletion of cause of
VITAI sician: T	certificate rector, pag	Be	25. Was case referred to medical examiner?	doenitat:		(Check only one)		
_ >	this c	မ	193 20110	Hospital: 1 ☐ Inpatient 2 × ER/Outpatier			ce 6 Other (Spec	ífy)
	ter ner	on:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury 28b. Time of Injury (Month, Day Year) Injury	Work?	28d. Describe how	injury occurred	. /
SIC tend teath	tor: /	cat	Accident investigation 3 Suicide 6 Could not be	2-27-04		FELL DOW	N STAIRS	AT HOME
DIVISION Hospital or Attending 24 hours after death.	al Director: Ai ed in by the fu	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify) 10901 BENNINGTON D		City or Town,	et and Number or Rui State) Jing on DR	LARGO MO
ne Hospi 124 hour	To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Phy	sician: To the best of my knowledge, death ner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
To the within 2	To the complet	ž	29b. Signature and title of certifier		29c. License number	290	I. Date signed (Month)	Day, Year)
			14/1/	1	D31069	A	PRIL 19, 20	204
(3	ye		30. Name and address of person who of DK GEORGE BONE	in pleted cause of death (Item 23a) (Type. 300) HOSPITAL	Print) DRIVE CHEVE	ERLY, M	PRIL 19, 21 D 20785	-
海尔 米 (1)	Sta Registr		APR 2 6 2004	32. Registrar's Signature		7		

Migu 04-0	el Angel 2977	M	artinez-Ramos <b>Please</b>	unpenditen#23a,27,I Type or Printin Blac	ÆR ME,G832,6/1 ck indelible ink	7/04eg c. Ensure All	Copies A	re Legible.	
RPD			1 - For State Registrer	State of Maryland /	Department of I			ene 2004	15460
	Physic /Medi			guel Angel Mar	tinez		2. Date of Death Month		3. Time of Death
20	Exami	ner	4a. Facility Name (If not institution, give Prince George's H  5. Social Security Number 6. Se	ospital Center	Chever	-	0.00.1	4c. County of Death	eorge's
36	Funeral Director		Usual Residence of Decedent	M 2□ F 21	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan 28,		nplace (State or Foreign untry) (EXICO
	death with the Maryland ms 23a or 28a-f show rmast be rediffed at	ector	Maryland Prince (		wn or Location Riverda	ıle			10d. Inside City Limits 1 ★ Yes 2 □ No
	Jeath with t ms 23a or 2	Funeral Director	10e. Street and Number 5309 Riverdale	12. Was Decedent Ever in U.S.		20801		g. Citizen of What Con  Mexic  14. Race - Amer	0
0	5 <b>2</b> 2 2 3 1	by	1X Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub 1 □ Wes 2 □ No			Black, White	e, etc.
4	within ene.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 9th	ucation 16a completed) College (1-4or 5+)	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of workin	g	6b. Kind of Business/I	
1	at yiding A should be filed nd Mental Hygi marked other amatic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Margarito Mar	tinez	Construc	tion Worke  18. Mother's Name  Pau			ie
2	ore, wary		19a. Informant's Name/Relationship (7) Eloy Martinez (B	Brother) 5	b. Mailing Address <i>(Street</i> 5610 54th Ave	and Number or Rural	Route Number, (	City or Town, State, Zi	p Code)
	Page Page nento ant: If ury or		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ♥ ↑ ↓ ☐ Donation 5 ☐ Other (Specify)	Bemoval from State Cemen	of Disposition (Name of ary, crematory or other plant tary Pozo Be	endito 5/8	3/2004 S		tosi, Mexic
<u>.</u>	permit. Departi Importa		21. Signature Fur eral Service Licens 23a. Party Enter the disease, or composite or heart failure. List each or the composite of the composite	Dend -	9013 Annaj	polis Road	, Lanham	, MD 20706	5
•	Pnysician /Medical Examiner		shock, or heart failure. List only of lamediate Cause (Final disease or condition resulting in death)	a. Arrythmia  Due to (or as a consequence		ng, such as cardiac or	respiratory arresi	<b>.</b>	Approximate Interval Between Onset and Death
ا	executed and inial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence					
6976	tificate be og physicial as the buri	ledical	C.	d					
9789 VOB O B	to the death certification by the attending place of the control o	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	/		23d. Date of deliv Month	ery Day Year
	w requires that	by	Part II. Other significant conditions cor	ntributing to death but not resulting i	n the underlying cause giv	en in Part I.		co use contribute to t	
Bec	icien: The law r certificate has be ector, page 2 sh	Completed					24a. Was an autopsy performed	d? death?	psy findings available mpletion of cause of
Division of Vital Records	Attending Physicien: The law requires that the death certificate be referr. After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the bur	atlon: To Be	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation		Time of 28c. Injury	y at 28		e 6 ⊡Other (Specifinjury occurred	v)
Divis	To the Hospitel or Attendi within 24 hours atter death. To the Funerel Director: A completely filled in by the t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			City or Town, S		
	the Hosp hin 24 hou the Fune npletely fii	Medicai	one)	sicien: To the best of my knowledge ner: On the basis of examination an and manner stated.	d/or investigation, in my of	pinion, death occurred	at the time, date	and place, and due to	the cause(s)
	To To		29b. Signature and title of certifier	*		e number C.M.E.		Date signed (Month, y 2, 2004	Day, Year)
CF.	3/		30. Name and address of person who co  AMA RUBIO  31. Date filed (Month, Day, Year)	, MD	(Type, Print) 111 Penn St	reet, Balt	imore, M	laryland 21	201
	Sta Registra	. •	MAY 0 4 2004	32. Registrar's Signature	mile				

	*		1 - For Amend Item #5 per fit 683 Registrar 4-28-04 Amend #4b. Per	<b>of Maryland /</b> <b>1 5/18/04 tas</b> Phys.PGC cr	Depa Cer	rtment of F	lealth and N Death	<u> </u>	reg. No.	004	15461
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Helen ( . M;	Is				2. Date of Dea Month	Day	Year Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and the Holy Cross Hospital			Poly Lvc	Location of Death	al	2/	of Death	
	Funeral Director		5. \$ <b>79-68</b> -5 <b>757</b> 0er 6. Sex	7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birtl (Month, Day June 9,	r, Year)		ace (State or Foreign try) h Carolina
	Aaryland I show	ō	Usual Residence of Decedent  10a. State  10b. County	10c. City, To	wn or Lo		1.			10	0d. Inside City Limits
	with the had or 28a-	Director	DC  10e. Street and Number			10f. Zip Code	shington 20019		10g. Citizen of	What Coun	,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: Hitem 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at Once.	/ Funeral	Armed  1 Never Married 2 Married 1 Yes.	ecedent Ever in U.S. Forces? s 2 1 X No		Vas Decedent of H I Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - America ck, WAife 1	an Indian,
21212-0030	in 72 hours "natural", fedical Exp	Completed by	15. Decedent's Education (Specify only highest grade complete	d)	a. Deced	lent's Usual Occup	ation during most of work	ing	16b. Kind of B		
	filed with Hygiene. other the		Elementary/Secondary (0-12) College 8th  17. Father's Name (First, Middle, Last)	9 (1-4or 5+)		Но	memaker 18. Mother's Nam	e (First, Middle,	Maiden Sumai	Priv	ate
aryland	d Mental d Mental nerked natic ev	To Be	Silas P. Corley  19a, Informant's Name/Relationship (Type, Print)	10	Ph Mailin	o Address /Street	and Number or Rur		Harris		Code)
Σ	and 2 sl ealth an m 27 is r		Robert T. Mills - Son		506	Mace Dr	., Ft. Wa		20744	•	
baltimore,	Pages 1 nent of H ant: If ite ury or oti		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	m State cemet	tery, cren	sition (Name of natory or other place oln Cemet	ery 4/10/		20c. Location Bren	twood	
סמור	permit. Departr Importe any inji		21. Signature of Funeral Service Licenses	mt TI	22	Name and Address A001 Be	ss of Facility S	tewart, N.E.			
	Physician		23a. Part1. Inter the disease, or complications that shock, in heart failure. List only one cause of	it caused the death. Do	o not ente	er the mode of dyin	ig, such as cardiac	or respiratory are	rest.		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	to or as a consequence	axt	tern di	دععلا				week
,	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	to (or as a consequence	e of): S ENS e of):	dive Sto	phy lo coc	(us mus	eus bac	tero la	weeks.
00/00	ficate be physicial s the bur	dical	d. End	-Stage re	nal	diyase	•				years
O. DOX	The law requires that the death certifi tte has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant	outcome of pregnancy e birth 2  Fetal deat gnant at time of death known		Ectopic pregnancy Other (specify)	,			ate of deliver	ry Day Year
, L	w requires that the been signed by should be detact		Part II. Other significant conditions contributing to	death but not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did to	_/		e cause of death?
H Record		Completed						24a. Was a autop: perfor	med?	prior to con death?	esy findings available apletion of cause of
V 11.0	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1	Inpatient 2 ER/C	Dutpatien	t 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	n (Check only or me 5 ☐ Resid	STORES OF THE	ner (Specify	
DIVISION OF VITAR	Attending Physician: r death. ector: After this certific by the funeral director,	ation; T	27. Man of Death 1 Natural 5 Pending (Maccident investigation	te of Injury 28b. onth, Day Year)	. Time of Injury	28c. Injun Worl M 1 🗆	y at k? Yes 2 □ No	28d. Describe h	ow injury occur	rred	
	Dire	Certification;	3 Suicide 6 Could not be determined 28e. Pla bui	ce of Injury - At home, ilding, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Town		ber or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction	Medical (	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the and m.	the best of my knowledge basis of examination a anner stated.	ge, death and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and ma late and place,	anner as sta and due to	ited. the cause(s)
	within 2 To the comple	Me	29b. Signiture and title of pertifuer	$\alpha \omega$		29c. Licensi		2	9d. Date signe		
)	(1)		30. Name and address of person who completed ca	use of death (Item 23a	i) (Type,	21.0	54099		April		
			Kall Ann W. Walls  31. Date filed (Month, Day, Year)  32		1220	or Plum	Drchard	Dr., Sil	ver S	ing,	MD 20904
A.	Sta Regist		APR 2 8 2004	de K	from	W.					

			For State	State of Marylan	d / Depa	artment of	Health and	Mental Hy	giene	
			Registrar  1. Decedent's Name (First, Middle, Last)	)	Ce	rtificate of	Death	2. Date of Dea	Reg. No. 200 ath Day Yea	3. Time of Death
*	Physicia /Medic Examin	al	KIMBERLY ANN  4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat	APRII		4 7:40 $A^{M}$
	Funeral	EI	National Institut  5. Social Security Number 6. Se	es of Health x 7. Age (In yrs.		Bethe	If Under 24 Hrs	(Month, Day	Montg	irthplace (State or Foreign Country)
7	Director		456-11-4575 Usual Residence of Decedent 10a. State 10b. County	4	8 Yrs.	ocation		Nov. 1	7, 1955 G	ermany  10d. Inside City Limits
1	28a-f sho	Director		es Parrish	Destr				10g. Citizen of What (	1 XYes 2 No
4	23a or	al Dir	108 Laura Lane				0047		USA	
350	De lied within 72 nous after death with the Maryand tal Hygiene. d other than "netural", or itams 23s or 28s-1 show event, the Medical Evaninar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, nite, etc. White
7	within /z hou iene. than "netura the Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give life.		pation during most of wo	rking	16b. Kind of Busines  Doctor of	sylndustry y Medicine
nd	d be filed we antal Hygier ted other th	Be	17. Father's Name (First, Middle, Last)  Daniel Lawrence M	5+	Veter	<u>inarian</u>		me (First, Middle, Ine Krich	Maiden Sumame)	y Medicine
Maryi	es 1 and 2 should be of Health and Mental litem 27 Is marked r other treumatic even	7	19a. Informant's Name/Relationship (T	ype, Print)		ing Address <i>(Stree</i>	t and Number or R		er, City or Town, State	, Zip Code)
ď.	rages 1 and nent of Health int: If item 27 iry or other tr		Chris LaGrange -  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 1  4 ☐ Donation 5 ☐ Other (Specify,	Removal from State St	lace of Disponentery, cre. Charl	osition (Name of matory or other pl es Borro	ace)	Date	20c. Location - City of Destrehan	
Baltir	permit. Pages Department of Important: If it any injury or conce.		21. Signature of Funeral Service Licens	1,1(0)	M	urch Cem <sup>2. Name</sup> and Add arshall 217 9th	ess of Facility S Funeral	Home, 1		
	nysician		23a. Pany. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the death one cause on each line.						Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq		FROM	CHEMO	74E2A	PY	1 WEEK
	be executed icien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. METAS TADue to (or as a conseq	vence of):	BREAS	F CAN	CER		NOV 2001
68/60,	eath certificate be executed attending physicien and for use as the burial-transit	ā		d. PRIMARY		AST C	INCER	,		BCT 2000
P.O. Box 6	The law requires that the death certificate the has been signed by the attending physpage 2 should be detached for use as the last the last the last the last last last last last last last last	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	⊒Ectopic pregnan ⊒ Other (specify)	су		23d. Date of d Month	lelivery Day Year
rds, P	w requires that the de been signed by the a should be detached	þ	Part II. Other significent conditions co	ontributing to death but not res	ulting in the u	underlying cause ç	iven in Part I.	23e. Did to	. 1	to the cause of death?  Probably 4 Unknown
Division of Vital Records,	the law renate has bee page 2 sho	Completed						24a. Was autop perfor 1 🗌 Yes	rmed/2   death'	autopsy findings available o completion of cause of ? es 2 \( \text{No}
Z I	certific rector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 □	55/0		ther	ath (Check only o		
on of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page	itlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inj	4   Norsing I		dence 6 Other (Sp now injury occurred	oecity)
DIVIS	ospital or Atter hours after dea uneral Diractor ly filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)		reet, factory, office	)	28f. Location (5 City or Tox	Street and Number or vn, State)	Rural Route Number,
:	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 10 Certifying Phyone) 2 Medicel Exem	ysicien: To the best of my kno liner: On the basis of examina and manner stated.	wledge, dea tion and/or in	nvestigation, in my	opinion, death occ	urred at the time,	date and place, and d	ue to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	ma			909 (NE	1	29d. Date signed (Mo	,
0	6		30. Name and address of person who d	completed caus of death (Iten	n 23a) (Type		202 (1411	,	04/23/	2004
1	0		MICHAEL R. BI	SHOP 10	CENT		E, BETH	ESDA, M	ARYLAND	20892
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 7 2004	32. Registrar's Signa	ture					

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2:15 PM April 2004 Adeline B. McKenney /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Nursing & Rehab. Center Clinton 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Yrs. 23, 1917 North Carolina 86 Director 578-03-2267 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State show r than "natural", or items 23e or 28e-f shov the Medical Examinar must be notified at 1X Yes 2 No Directo Prince George's Clinton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20735 United States 9211 Stuart Lane Funeral 14. Race - American Indian, Black, Whiterefccan 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status a filed within 72 hours after di if Hygiene. other than "natural", or item 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Importent: If item 27 is marked other the any injury or other treumatic event, Image. Federal Employee Government 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Addie Branch John Bragg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 95 W.95th St., Apt. 33E, New York, NY Joseph L. Bragg - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial park 4/27/2004 Landover, MD 21. Signature of Flyneral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 lutar 23a. Part 1 (Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Renal Disease **Physician** /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine cale has been signed by the attending physician and page 2 should be detached for use as the burial-transit the death certificate be executed Coronary Artery Disease Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Hypertension Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed? within 24 hours after death.

To the Funerel Director: After this continue completely filled in house. 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 yoursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4-21-04 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Ave., S.E. #310, Wash., DC Bahram Pishdad, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 6 2004 Registrar

			For State Registrar	State of M	laryland	•		t of He		nd Me	ental H	ygiene Reg. No	2001	151.	61.
	Physicia	an	Decedent's Name (First, Middle, Las	t)							2. Date of E Month	eath Da	y Year	3. Time of D	Death
	/Medic Examin	al	Eloise Berry 4a. Facility Name (If not institution, give		tthews	3	4b. City,	Town, or L	ocation of		April		2004 :. County of Dea	12:40	AM™
	Examili	EI	14539 Jackson Bo	oulevard			Ede						Wicomic		
	Funeral Director		052-26-2522	7. A	70 nge (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of B. (Month, L August	ay, Year)		thplace (State or ountry) WYORK	Foreign
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation			-, -,				10d. Inside City	
	Be-f sh	Director	Maryland Wicomic	20	Ede	en							·	1 ☐ Yes	2) No
	with the	Dire	10e. Street and Number 14539 Jackson Boul	levard			10f. Zip	1822				10g. Cit	tizen of What C USA	-	
<b>'</b> O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If lem 27 is merked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner mast be nutified at any injury or other treumatic event, the Madical Examiner mast be nutified.	Funeral	11. Marital Status  1 Never Married  Married	12. Was Deceden Armed Forces	?		Vas Decer f Yes, spe	dent of Hisp cify Cuban,	Mexican,	in? (Speci Puerto Ri	ify Yes or Nican, etc.)	lo-	14. Race - Am Black, Wh		
903	urai', o	<u>م</u>	3 Widowed 4 Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes		Specify:				Specify:	White	
Maryland 21215-0036	vithin 72 t ne. han "natu a Medica	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de <i>co</i> m <i>pleted)</i> College (1-4or	r 5+)	life. L	ent's Usua kind of wo DO NDT us ecret	rk done du se retired)	ion ring most	of working	7		Gind of Busines: Keen We		
ў Д	e filed v I Hygie other t	Be Co	12 17. Father's Name (First, Middle, Last)			٥	ecret		8. Mother	's Name (	First, Midd		Sumame)		
ylar	ould be Menta varkad vatic ev	ToE	George	Berry		40. 11.		/2:	Haz				Inknown	7.000	
Mar	nd 2 sh lith and 27 is rr r treum	1	19a. Informant's Name/Relationship (7) Charles E. Matthe		band)		-						or Town, State, eryland	21822	
ore,	of Hea of Hea f Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Pl	lace of Dispo	natory or c	ther place)	1	Da			ocation - City o		
Baltimore,	t. Pag rtment rtant: h njury o		* 4 Donation 5 ☐ Other (Specify	)	Scr	00	Mana		of Conilibra					aryland	
Ba	Depa Depa Impo any is	1	nature of Juneral Service Licen	MODON	CF	_ H	ollo	vav Fi	unera	ıl Hor	me Pro Salia	ofess sbury	sional A	Association 218	ion 804
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause	line.	. Do not ente	er the mod	le of dying,	such as c	ardiac or	respiratory	arrest,		Approximate Interval Betw Onset and De	een
Ē	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Oue to (or a	-	>+ c	/	tor	+	F	ilure	-		3 Y	د
	Examiner		Sequentially list conditions,	b											
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o,	icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or a	s a consequ	ience of):									
68760,	icate b physic s the bi	dical		d											
Box (	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 ☑ No	23c. If yes, outcom 1☐Live birth 4☐Pregnant	2 🗌 Fetal	death 3	Ectopic po						23d. Date of de Month		ear
P.O.	that the de ed by the a detached f	hysl	9 🗌 Unknown	9□ Unknown											
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the ur	nderlying o	ause given	in Partl.			Yes 2		o the cause of de robably 4 ∐Ur	
Division of Vital Records,	0 L 0	Completed									24a. Wa aut per 1  Yes	opsy formed?	prior to death?	utopsy findings a completion of car s 2 \( \subseteq \text{No} \)	vailable use of
/ital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:					-	of Death (	Check only			- 850	
n of \	ing Physician: Viter this certific uneral director,	on; To	1 ☐ Yes 2 ♣No  27. Manner of Death 1 ♣Natural 5 ☐ Pending	28a. Date of In (Month, D	jury	ER/Outpation 28b. Time of Injury	2	28c. Injury a Work?	at	28			6 ☐Other (Speny occurred	ecify)	
ivisio	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I	njury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factor		es 2∐N	_	f. Location City or T	(Street ar own, State	nd Number or F a)	lural Route Numb	er,
	Hospitel Hospitel Hours a Funeral [	edical Ce	(Check only 2 Medical Exem	ysician: To the bes	of examinat										
	To the l within 2- To the I complet	Med	one) 29b. Signature and title of certifier	and manner	siateo.		290	c. License i	number			29d. Da	te signed (Mon	th, Day, Year)	
-2	210		1/0/				J	200	54	879		04	126/	04	
0	M		30. Name and address of person who	completed cause of	-	23a) (Type,	Print)	M. Ti	ruet.	h	Mis	7/	80/		
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 7	2004 32. Regis	ar's Signa		1	pork	2				- /		

Physici		1 - State Registament TIFM #20d F  1. Decedent's Name (First, Middle, Last) Edward			1cDonne11		2. Date of De	ath	2004 Year	3. Time of Death 11:05 P	
/Medic Examir		4a. Facility Name (If not institution, give s Millenium Health &	treet and number)			or Location of Deat		40	County of Death		
Funeral Director		5. Social Security Number 013-14-9246 Sex	7. Age (In yrs. Ia 84	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Year, 1919	9. Birthp Cour Mass	place (State or Fore ntry)	
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-f show that the Medical Exams wit must be traffiled at	Director	10a. State 10b. County  Maryland Prince Ge		v, Town or Lo Wash:	ington					0d. Inside City Lim 1 ☐ Yes 25€	
23a or 2	al Dir	10e. Street and Number 1213 Firth of Lor	ne Circle		10f. Zip Code 2074	<b>.</b> 4		-	tizen of What Coul SA	ntry?	
halfygiene.  Adother than "natural", or Itams 23a or 28a-f show event, the Medical Exandration interest confilled at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Narried  1 Narried Narried 2 Narried  1 Narried Narried 2 Narried  1 Narried Narried Narried		Nas Decedent of Hispanic Origin? (Specify Yes or No I Yes, specify Cuban, Mexican, Puerto Rican, etc.) I ☐ Yes 🏋 No Specify:			- 14. Race - American Indian, Black, White, etc. Specify: White				
than "natura	Completed	(Specify only highest grade completed) (Give kind of the completed) (Give			kind of work done during most of working OO NOT use retired)				6b. Kind of Business/Industry		
e d S	Be Co	17. Father's Name (First, Middle, Last)		A_	ITCIALL P	18. Mother's Nar	ne (First, Middle,	Maider		ıstry	
snod Menta s marked umatic ev	Tol	Daniel Joseph McI  19a, Informant's Name/Relationship (Ty)		19b Mailir	a Address /Street		phine Ga		y or Town, State, Zip	Code	
of Health and Ment	1 8	JoAnn D. Dullahan							sh $MD$		
nent of He int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ R	20b. Pl	ace of Dispo metery, crer	sition (Name of natory or other pla	ce)	Date	20c. L	ocation - City or To	own, State	
Department of I		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of neral Service Dcense							gewater,		
Deg in a	/ //	1 / / 12 /	Cakez	61	60 0xon	George <u>Hill Roa</u>	P. Kalas d Oxon H	Fui	neral Hom , Marylan	ne P.A. id 20745	
nysician /Medical xaminer		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	CAN	JCER	ig, such as cardiac	s or respiratory ar	rest,		Approximate Interval Between Onset and Death	
hysicien and the burial-transit	Ilcal Examiner	d									
ite has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Was decedent pregnant in the past 12 months?  1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N						23d. Date of delive Month	ory Day Year	
been signed b	by	Part II. Other significant conditions con						Did tobacco use contribute to the cause of de			
(0 00	Completed						24a. Was autop perfo 1 ☐ Yes	sy rmed?	prior to cor death?	psy findings availa npletion of cause of	
	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ER/Outpatien	t 3 DOA Oth	th (Check only one)  ome 5 Residence 6 Other (Specify)						
death. ctor: After this y the funeral di		27. Manner of Death 1 ☒ Matural 5 ☐ Pending 2 ☐ Accident investigation	1			28d. Describe how injury occurred			7		
olite in b	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
W W W	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) date and	) and manner as st d place, and due to	ated. the cause(s)	
within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens				te signed ( <i>Month</i> , il	Day, Year)	
		D48158  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)#500					03/20/2				

				State of Maryla	nd / Depa <i>Ce</i>	artmer <i>rtifica</i> i	nt of F <i>te of</i>	lealth ar <i>Death</i>	id Mental Hy	/giene 2 Reg. No.	004	15461		
П	Decedent's Name (First, Middle, Last)  Physician						2. Date of De Month	Day Year		3. Time of Death				
N	/Medi	cal	JAMES J. NO					APRIL	21, 2004 1:		11:00 PM			
- A	Exami	ner	4a. Facility Name (If not institution, give WASHINGTON ADVEN								y of Death TGOMEF	₹Y		
	Funeral				– s. last birthday)		r 1 Year	If Under 24	Hrs. 8. Date of Bi	rth	,	ace (State or Foreign		
ı	Director		3/9-36-6406	□M 2□F	58 Yrs.	Months	Days	Hours	MAY 22	, 1945	DC DC	79)		
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation					11	Od. Inside City Limits		
	Maryl Ff sho	to	MD PRINCE G		JITLAND						'	1 ☐ Yes 2 ᡮ No		
	th tha	Director	10e. Street and Number			10f. Zip	p Code			10g. Citizen of	What Coun	iry?		
	ath with the Marylan 23e or 28e-f show	ralD	5761 SUITLAND RE	).		2	20746	3		USA				
	er da:	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Dece If Yes, spe	dent of H	lispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	o- 14. Ra Bla	ce - America			
020	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 DDivorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes	a∏ No	Specify:		Specia	y: BLA	<b>ICK</b>		
21215-0020	72 hours after daath with tha Maryland natural', or items 23a or 28a-f show Ilcal Evaminer must be notified at	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usu	el Occup	ation		16b. Kind of B	lusiness/Ind	ustry		
21	ithin in ithin in ithin in ithin in ithin in ith	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			se retire	during most of d)	working					
	iled w Hygier ther th	To Be Cor	10 17. Father's Name (First, Middle, Last)		LAB	ORER		10 Mathada	Name (First Affects	TIRE (		IY		
lan	d Mental I		JAMES J. NORMAN,	т					Name <i>(First, Middl</i> e H CURTIS	, walden Sumal	ne)			
Maryland	shou and M s marl	-	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address	s (Street			Rural Route Number, City or Town, State, Zip Code)				
	and 2 salth a 27 te er tra		JAMES J. NORMAN,	III (SON)	319	GROVE	PAF	RK RD.,	<b>BROOKLYN</b>	, NY 212	225			
Baltimore,	ges 1 and 2 should be filed within 72 hours after daa to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items or other traumatic event, Ite Medical Examinal in		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I		Place of Dispo cemetery, cren	sition (Nai natory or c	me of other plac	œ)	Date	20c. Location	- City or Tov	vn, State		
Itim	it. Partmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify,	FT	. LINCO				4/28/04		TWOOD,	MD		
Ba	parmit. Pages 1 and 2 Department of Health s Important: if Item 27 is any injury or other tra once.		21. Signature of Funeral Service Licens					ss of Facility	PEYTON F			00000		
			23a. Part1. Enter the disease of comp shock, or heart failure. List only of	lications that caused the dea					TON RD.,					
-	Physician		shock, or heart failure. List only o	ne cause on each line.			<b>.</b>	3,	out or roop haroly a		1	Approximate Interval Between Onset and Death		
1	/Medical Examiner		Immediate Cause (Final disease or condition	· Cardinh	· hu		. 4	2202-			H	fall how		
	Examiner	6	resulting in death)	Due to (	or as a conseq	uence of):	1	vine.				_		
	uted d ansit	Examiner		. Congestin	or as a conseq	dias	F	aline		-1-		Wo Weels		
o,	e exec	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq	uence on:						talf how two weeks Tew years		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Lass								ew - Jeans						
9 X	n certific anding p usa as			d							 			
Box	atte for	by Physician/N									- 1			
P.O.	that tha de ed by the detached	hys	Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	nderlying c	ause give	en in Part I.		lobacco usa co Yas 2 □ No	ntributa to t 3 □ Proba	tha causa of death?		
	as tha igned be del	و م							_	Tas ZLINU	3   FIUDE	Diy 4,20 Offictiown		
of Vital Records,	v require been si should I	ged								an autopsy rmed?	avai	e autopsy findings lable prior to		
3ec	has by	Completed			· · · · · · · · · · · · · · · · · · ·						of de	pletion of cause eath?		
alF									101	res 2. No	1 🗆	Yes 2□ No		
N N		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	lospital: 1 Anpatient 2	1 EB/Outpetiest	a□ 00	Othe	AP.	Death (Check only o		<b>10 11</b> 1			
סר	g Phys er this neral di		27. Manner of Death	28a. Date of Injury 28b. Time		of 28c. Injury at			Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred					
Sior	Attanding ir daath. ector: After by the fune	atio	1 Matural 5 ☐ Pending investigation	(Month, Day Year) Inj				r res 2□No	2 □ No					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	et, factory	, office		28f. Location (5 City or Tow	Street and Numb m, Stete)	er or Rural i	Route Number,		
	To the Hospital or Attanding is within 24 hours aftar daath. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Cartifying Phys	sician: To the best of my kno	wledge death	occurred a	at the tim	o data and ale	and due to the					
	e Hos	edlcai	(Check only 2 Medical Exami	nar: On the basis of examina and manner stated.	ation and/or inv	estigation,	in my op	inion, death o	ccurred at the time,	date and place,	and due to t	ed. ne cause(s)		
	To the within 2 To the comple	ž	29b. Signature and title of certifier				. License			29d. Date signed				
			> Mkan	- MD			DI	8895	•	April:	27, 3	2004		
)	(4)		30. Name end address of person who co	-11	m 23a) (Type, F	Print)	-2/1/	TILL	OMA PARI	Z. Mh	209	1).		
	Sta		MOBARAL KAIZIM 31. Date filed (Month, Day, Year)	7610 CAR ROLL	ature	215	740	) IKE	CHRITIE-1	1 1 1 1		12		
	Sta Registra		APR 2 9 2004	2. Registrar's Signa	hours	80								

			1 = For State Registrar	State of Maryland			of Health a of Death	F	Reg. No. 2	004 1546	
9	Physici /Medi	cal -	Decedent's Name (First, Middle, Last)     Ryan McPherson  4a. Facility Name (If not institution, give state)	O'Neal, Jr.		Ab City Toy	wn, or Location of	2. Date of Dea	Day	3. Time of Death	
1	Examir	ner	Holy Cross Hospi				er Spri			ntgomery	
	Funeral Director	1000	5. Social Security Number 6. Sex 056-68-9531		ns <i>t birthday)</i> Yrs.	If Under 1 Y		-		9. Birthplace (Stete or Foreigr Country) Silver Spring	
	Maryland e-f ahow	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Prince		Town or Lo	ocation				10d. Inside City Limits 1 X Yes 2 □ No	
	with the	Dire	10e. Street and Number 210 Jill Lane T-	1		10f. Zip Co			10g. Citizen of	What Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23s or 28s-f ahow any injury or other treumatic avant, Ite Medical Erantment to Itemitial at another.	Completed by Funeral Director		12. Was Decedent Ever in U.S Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:			of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)		ce - American Indian, ck, White, etc.	
21215-0036	hin 72 ho In "netur Medical		15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed)	16a. Deced (Give life.	dent's Usual O kind of work d DO NOT use r	ccupation lone during most etired)	of working	16b. Kind of B	usiness/Industry	
,TZ b	filed with Hygiene other tha	0	n/a  17. Father's Name (First, Middle, Last)	College (1-4or 5+)		n/a	infan	s Name (First, Middle,	n/a Maiden Suman	IllIalli	
/lan	uld be Wental Irked o	To B	Ryan M. O'Neal				Ebony	A. Hinds-	Evans		
Maryland	d 2 sho th and I 7 is me treum		19a. Informant's Name/Relationship (Ty) Ryan O'Neal/Father					or Rural Route Number	-		
re,	theal them 2 other		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other	of	Date Date		- City or Town, State	
Baitimore,	Page ment c tent: # jury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	Ba1	timore	e Crem.	at LP	3/1/04		more, MD	
Bail	Depart Depart Import any in		21. Sign turn of Funeral Service Cense	7.400 Cal		LMpIe T 040 Roc	ddress of Facility ribute F kville P	uneral and ike Rockvi	Cremat	ion Center	
).  }.	Physician /Medical	(	23a, Part Enter the disease, or complishock, or heart failure. List only or mmediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.  Carolo 1	Do not ent	er the mode of	dying, such as c	ardiac or respiratory ari	est,	Approximate Interval Between Onset and Death	
1,097	ate be executed XX XX YX YX YX YX YX YX YX YX YX YX YX	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a)	ence of):	nation	:ty.			15 has	
O. BOX 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as th		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregn Other (specif				te of delivery onth Day Year	
7	quires that n signed b ald be deta	by	Parti. Other argument community to death but not resoluting in the unuallying cause given in Parti.						tobacco use contribute to the cause of death?  Yes 2 \( \subseteq \text{No} \) 3 \( \subseteq \text{Probably} \) 4 \( \subseteq \text{Unknown} \)		
Vital Records,	The law requir ate has been si page 2 should	Completed						24a. Was a autops perfor	nyed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
<u>  [a</u>	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital: , e			26. Place of	of Death (Check only or	16)		
ō	Phys rthis ral di	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury		Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
DIVISION	I or Attending Physicien: after death. Director: After this certific I in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year)  28e. Place of Injury - At hor	ne, farm, str	Injury Work?  M 1 Yes 2 No  farm, street, factory, office 28f. Location			(Street and Number or Rural Route Number,		
ă	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	edical Cert	29a. Certifier 1 ertifying Phys	building, etc. (Specity) sician: To the best of my knowner: On the basis of examinati	vledge, death	occurred at the	ne time, date and my opinion, death	place, and due to the coccurred at the time, d	ause(s) and ma	anner as stated. and due to the cause(s)	
	To the P within 2 To the R complete	Med	29b. Signature and title of certifier	and manner stated.			cense number			d (Month, Day, Year)	
•	+ 3 <del>+</del> 8		Dupy Dun	ampleted cause of death (Item	23a) (Tupo	1+1	00459	52	02-1		
			GREGALY J. D	MEL ANIMA	Fore	t Glen	La silve.	Spring, ME	)		
	Sta	ate	31. Date filed (Month, Pax, Year) 3 2	32. Registrar's Signati	TIE	perfe		)			

			1- For State of Maryland / Dep	partment of Health and I		iene 19. No. 2004	151.69
*	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Deat	Day Year	3. Time of Death
يتر.	/Medic	al	DONALD JEAN PETRY, SR.	4b. City, Town, or Location of Death	MAY 1,	4c. County of Death	1:37 PM
	Examin	ier	4a. Fecility Name (If not institution, give street and number) CARROLL HOSPITAL CENTER	WESTMINSTER	1	CARROL	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 220-34-6652 120M 2 F 67 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, MARCH 9	Year) 9. Birthp Cour 1937 WES'	lace (State or Foreign atry) VIRGINIA
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
	Maryl -1 sho	tor	MARYLAND CARROLL WESTM	INSTER			1 ☐ Yes 2√2 No
:	or 28a	Olrec	10e. Street and Number	10f. Zip Code		g. Citizen of What Cour	•
	s 23a	eral (	324½ EAST MAIN STREET	21157		JNITED STAT	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Importent: If item 27 is marked other than "naturs!", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notilled at once.	by Funeral Director	11, Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give 1 Yes, Give 1 Year or Dates:	Was Decedent of Hispanic Origin? (Single of Yes, specify Cuban, Mexican, Puerton of Lambda of Yes 2 No Specify:	o Rican, etc.)	Black, White,	etc.
2-0	72 hor	eted	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of work	king	6b. Kind of Business/In	dustry
21215-0036	within ane. than	Completed	Elementary/Secondary (0·12) College (1-4or 5+)	LABORER		LANDSCAPING	3
	illed Hygie other	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
Vlan	should be ind Mental marked o umatic eve	To B	DONALD PETRY	DOROTH	Y CHALLIS	3	
Maryland	12 sho h and 7 is m traum			iling Address <i>(Street and Number or Ru</i> 12 EAST MAIN STREET		-	<i>Code)</i> 21157
	Health tem 27 other tr		20a Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)		20c. Location - City or To	
m e	Pages nent of ant: If it ary or o			CREMATION 5/3/	2004 I	HAMPSTEAD, I	MARYLAND
Baltimore,	permit. Departnimporte any inju		21. Signature of Funeral Service Licensee	Myers-burborāw fun 91 willis street,	ERAL HOME WESTMIN	E P.A. ISTER, MD 2	21157
F			23a. Part1. Enter the disease, or complications that cause the death. Do not a shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	togina			Onset and Death
H	/Medical Examiner		Due to (or as a consequence of):	· poelaneen			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	pertipich			
)	ate be executed inysicien and the burial-transit	Examiner	Cause (Disease or injury that intiated events resulting in death) Last  C	Dellipide	oma		
87600	sicien burial	cal E	Due to (b) as a consequence (i).	·			
Ö	tificate ig phy: as the		0.				
P.O. Box	Attending Physicien: The law requires that the death certificate be executed reach. reach. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
	res that signed by	y Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tob	acco use contribute to the	e cause of death?
ord	w require been sig should b	o Be Completed b	Right Subclair	an oeum	1□Ye	s 2□No 3☑Prob	ably 4 □Unknown
al Records,	ysicien: The law r is certificate has be director, page 2 sh		V		24a. Was ar autopsy perform 1 Yes 2	prior to condeath?	psy findings available inpletion of cause of
Vital	sicien: Th certificate irector, pag		25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ FR/Outpat	Other	th (Check only one	nce 6 Other (Specifi	1
1 0	ig Physier this	<del> </del>	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe ho		//
Sior	Attending Pher death. ector: After the by the funeral	catlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town	eet and Number or Rura State)	l Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical Ce	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, de (Check only one)  Certifying Physicien: To the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as si te and place, and due to	ated. the cause(s)
ļ	To the within To the comple	Med	29b. Signature and title   certifier	29c. License number	29	d. Date signed (Month)	Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	01/10	on PA	-
			KAJANI TADIMALLA M	D 912 W	well	mirule	1 MD 2116
48	Sta Registi		31. Date filed (Month, Day, Year)  32. Register's Signature	Sportes"			
DI	11.5151	004	HITT I O LOUI JUSTICE JO	Marie			

		-	1 - For Stata Ragistrar	State	of Marylar		artment o		nd Mental Hy	giene Reg. No.200L	15469
	Physici /Medio	an	1. Decedent's Name (First, Middle Lillian B.	. ,					2. Date of De Month	ath Day Year	3. Time of Death
	Examin	er	4a. Fecility Name (If not institution Heartland Hea 5. Social Security Number		· ·	1	,	n, or Location of yattsvi sar   If Under 2	11e		George's
	Funeral Director		577-84-3262 Usual Residence of Decedent	1 □ M 2X0 F	102	Yrs.	Months Da		Min. 8. Date of Bir (Month, Da	y, Year) 7, 1901 M	nthplace (State or Foreign country) [aryland]
	Ba-f show	Director	DC 10a. State 10b. County		10c. Cit	ty, Town or Lo	Wa	shingto	n	10-00	10d. Inside City Limits 1 X Yes 2 No
	th with the 23e or 2 and Le m	al Dire	10e. Street and Number 2207 Otis St	., N.E.			10f. Zip Cod	2001	8		States
920	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, the Madical Evaninar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	Armed F ried 1 ☐ Yes	2 XNo ive		Was Decedent If Yes, specify 0 1 ☐ Yes 2 五		jin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
Maryland 21215-0036	within 72 ho ane. than "natur te Madical	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12 th		) (1-4or 5+)	(Give	DO NOT use re	ne during most	of working	16b. Kind of Busines	
land 2	be filed ital Hygi od other event, I	To Be Co	17. Father's Name (First, Middle,  Robert Bo				nous	7	r's Name <i>(First, Middl</i> e, Blanch		ate
Mary	12 sh h and 7 ie m treum	_	19a. Informant's Name/Relations Romaine Jenk		ghter		•		r or Rural Route Numbe .E. Wash.,		Zip Code)
Baltimore,	Pages 1 and 2 nent of Health ant: If item 27 i ury or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from	State	cemetery, cre	osition (Name or matory or other	place)	Date 4/23/2004	20c. Location - City o	
Baltir	permit. Pages Department of Important: If it any injury or once.		21. Signal ure of Funeral Service		A TIL		2. Name and Ad	dress of Facility	Stewart E Rd., N.E.	Funeral Hom	
	Physician /Medical		23a. Part Enter the disease, or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	caused the deal each line.	Fibri	er the mode of	dying, such as o	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
,	be executed sician and intransit burial-transit	Examiner	S squartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>6</b>	(or as a consec		,				
68760,	fficate be g physicia as the buri	ical		d							110
O. Box	nt the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	1 ☐ Live	atcome of pregn birth 2 ☐ Feta mant at time of c nown	al death 3	∃Ectopic pregna ∃ Other <i>(specif</i> y			23d. Date of de Month	alivery Day Year
S, P.	rires tha signed d be de	ρ	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause	given in Part I.		obacco use contribute Yes 2 No 3 F	to the cause of death?  Probably 4 Munknown
Il Record		Completed									
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ▼No	Haspital	Inpatient 2	ER/Outpatie	nt 3 DOA	Othor	of Death (Check only or sing Home 5 Residual)		acifu)
of	fing After fune		27. Manner of Death  1 Natural 5 Pending invest	28a. Date ng (Mo igation	of Injury ofth, Day Year)	28b. Time of Injury	f 28c. I	njury at Work? 1 □ Yes 2 □ N	28d. Describe I	now injury occurred	July
Division	i Sit o	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Plac	e of Injury - At h ding, etc. (Speci	ome, farm, st	reet, factory, off	ice	28f. Location (: City or To	Street and Number or F vn, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical		Examiner: On the					d place, and due to the h occurred at the time,		
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certific	er h			29c. Lic	ense number	7.0	29d. Date signed (Mor	th, Day, Year)
	COP		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type,	Print) 7L	180	Jew Ha	mpsh	104.
	ع العر		#210,1	angle	Registrar's Sign	ank	, w	0.5	0912	Dr. Alexa	ender WKOK
1	Sta Regist		APR 2 6 2004	Kleen 32.	registral s Sign						

iis	Poston		For State	State of Maryland	•	artment of F				200	. 16170
			Registrar  1. Decedent's Name (First, Middle, Last	)	Cel	lilicate of	Dealii		Re Date of Death	g. No.L. UU	3. Time of Death
4.3	Physici /Medio		LOUIS	POSTON					Month pril 2	Day Yes	1130 a <sup>M</sup>
)	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o				4c. County of D	eath
			Prince Georges Ho			Chever	-	0.4.11			e Georges
	Funeral Director		5. Social Security Number 6. Se	x 7. Age ( <i>In yrs. la</i> 3. Age ( <i>In yrs. la</i>	st birthday) Yrs.	If Under 1 Year Months Days	If Under:	Min. 8. 0	Date of Birth Month, Day,	1985 Ma	Birthplace (State or Foreign Country)
			219-11-0500 Usual Residence of Decedent	10					3	1905 Ma	Tyland
	show	_	10a. State 10b. County		, Town or Lo						10d. Inside City Limits
	ith the Marylar or 28a-f show	ecto	MD Prince G	eorge's La	indove				40		1 ☐ Yes 2 ☐ No
	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23s or 28s-f show event, I'rs Modical Examination is usi be notified at	Funeral Director	1701 Belle Haven	Drive		10f. Zip Code 20785	5		10	g. Citizen of What U.S.A.	Country?
	death death	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Orig	gin? (Specify	Yes or No-	14. Race - A	merican Indian,
36	or ite	y Fu	1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 Tes, specily Cuba 1 □ Yes 2 ☑ No	Specify:	i, Puelto Nica	п, өкс.)	Black, W Specify: ]	· ·
ő	hours tural',	ed by	3 Widowed 4 Divorced  15. Decedent's Edu	Year or Dates:		ient's Usual Occup			1 4		
15	nin 72 n "na Mulic	plet	(Specify only highest grad	le completed)	(Give	kind of work done of NOT use retired	during most du	t of working	1	6b. Kind of Busine	ss/industry
212	d with giene er the	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Stu	ıdent				Private	
pu	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)					,		aiden Sumame)	
ya	should ind Men	2	James Poston III		105 14-15-			elina H			7.0
Maryland 21215-0036	id 2 st Ith and 27 is n treun		19a. Informant's Name/Relationship (T) Velina R. Exum/Mo			ng Address <i>(Street :</i> Belle Ha					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, I'm Mudical Examinactional be notified at once.	1	20a. Method of Disposition	20b. Piz		sition (Name of natory or other place		Date		Oc. Location - City	
altimore,	Page nent o unt: If ury or		1 Surial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)	terilovas irolli State		Cemetery		5/3/20	04	Landover	Marvland
alti	permit. Departn Imports any inju		21. Signature of Funeral Service Licens			. Name and Addres	ss of Facility			INS FUNE	
	205 20		K.D. Harsh	all		74 Lando					
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	. Do not ent	er the mode of dyin	g, such as	cardiac or res	spiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. QuiShot	الكار	und c	rt Y	1000	k		
	Examiner			Due to (or as a conseque	ence or):						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Under the Cause (Disease or injury	Due to (or as a conseque	ence of):						
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to /or or o							
8760,	be ey cian buria			Due to (or as a conseque	erice or).						
687		edicai		J							
Вох	eath certifi attending for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pregnancy				23d. Date of c	lelivery
	ie death the atte	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea		Other (specify)				Month	Day Year
P.0	that the de ed by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions con	atributing to death but not resul	ting in the ur	derlying cause give	an in Part I		23e Did toba	cco use contribute	to the cause of death?
Vital Records,	se. De pe	d by	Takin and olympian	Wildeling to dodin partio, room	ang ar are di	labilying caass give	911 111 1 GULL.		1 🗆 Yes	<i>i</i> /	Probably 4 Unknown
CO	w requir	iete							24a. Was an	24b. Were	autopsy findings available
Re	The lav	Completed							autopsy performe	death	
ital		BeC	25. Was case referred to medical examiner?				26. Place	of Death (Ch	/>	No Y	95 2 140
of V	physic this ce al dire	2	1⊠ Yes 2□ No		R/Outpatien		4 🗀 INUI	rsing Home	5 🗌 Residen	ce 6 ⊡Other (S <sub>F</sub>	pecify)
ou c	ding Ph  After th funeral	ion:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl		28d. I	Describe how	injury occurred	ant
Division	tor: the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hon	ne, farm, stre	eet, factory, office	183		ocation (Stre	et and Number or	Rural Route Number,
D	afte Dir	Certification;	4 Homicide	28e. Place of Injury - At hon building, etc. (Specily)	00	lot		30	OS TOWN.	State +50	* Roal
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my know	ledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and pinion, deat	d place, and d h occurred at	fue to the cau the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
	o the ithin o the orthe	Med	29b. Signature and title of certifier	and manner stated.		29c. License				I. Date signed (Mo.	
	F 3 F 8		Water Are	m.11-20	Ode	OCME				April 25,	
0	[2]	1 3	30. Name and address of person who co	ompleted cause of death Item	23a),(Type, I						
_			YADRICIA AS	0101CA-1611	AKI	H111 P	enn St	treet,	Baltin	more, Mar	yland 21201
The state of the s	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 8 2004	82. Registrar's Signatu	Ire Angel						

		1 - For State Registrar	State of Marylar	d / Depa		Health and	Mental Hy		•	15	471
Physic		Decedent's Name (First, Middle, I No1a MAe	Perry				2. Date of De Month 04	Day	Year 2004	3. Time of 4:25	f Death A M
/Med Exam		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Dea			ounty of Deeth		
		Montgomery Gene	ral Hospital		01ne			Мс	ntgomer		
Funera Directo		239-24-2863	Sex 1□ M 2\ F 83	last birthday) Yrs.	Months Day			th y, Ye <i>ar</i> ) 20	9. Birthp Cour North	olace (Stete contry) 1 Caro	or Foreign lina
nyland how		Usuel Residence of Decedent  10a. State 10b. County		ty, Town or Lo					1	0d. Inside C	•
the Ma 28a-f	Director	MD Montgot	mery Si	lver S	pring			14 Yes 2 No			2   NO
h with		2601 Bel Pre R	oad		2090		USA			iti y r	
be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "naturel", or Items 23a or 28a-f show event, the Modical Exercities must be motified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces?		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2√2 N	Hispanic Origin? ( ban, Mexican, Pue o <i>Specify</i> :	Specify Yes or No no Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc.  Specify: Black			
thin 72 hours affile.	Completed	15. Decedent's (Specify only highest s	Education trade completed)	16a. Dece	dent's Usual Occ kind of work don DO NOT use reti	e during most of we	orking	16b. Kind of Business/Industry			
d with giene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Nurse			St. E	lizabet	hs Hos	spital
Adl yidild Z 2 should be filed v and Mental Hygie is marked other reumatic event, it	To Be (	17. Father's Name (First, Middle, La. Walter McCloud	st)				me (First, Middle, A. Evans		'umame)		
2 shou and N is mai	Γ.	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Stree	et and Number or R	lural Route Numbe	er, City or	Town, State, Zip	Code)	
and and lealth m 27		Jacqueline Bibik				rive, Woo	odbridge,			0	_
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumatic a monea.		20a. Method of Disposition 1X Burial 2 □ Cremation 3	Themoval Irolli State   Do.		osition (Name of matory or other pi ek Cemet				ation - City or To ington,		
Definition  Definition Pages Department of mportant: If it is any injury or o		' 4 ☐ Donation 5 ☐ Other (Special Service Lice)	,y)			ress of Facility Ma					
Depa Impo Impo		Do ma	shall,			St. N.W.					
Pnysician		23a. Party. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused the deat by one cause on each line.	h. Do not en	ter the mode of dy	ying, such as cardia	ac or respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
/Medical Examine		resulting in death)	Due to (or as a consec	-	a IIIaar						
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Sacral Dec		s orcer				-		-
certificate be executed adding physician and use as the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	uence of):							
ificate g phys			d.						(7' <u>-</u>		
death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	☐Ectopic pregnan☐Other (specify)	cy		23	id. Date of delive Month	•	Year
) % 5g	þ	Part II. Other significant conditions Pneumonia	contributing to death but not res	ulting in the u	inderlying cause g	iven in Part I.			o contribute to the		
<b>&gt;</b> 20 00	Completed	Diabetes Mell	itus				24a. Was	an	24b. Were auto prior to cor death?	psy findings	available ause of
The cate has	Con						perfo 1 🗆 Yes	rmed? 2X No	death? 1 ☐ Yes	2 No	
Physicien: Tribis certificat	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ZInpatient 2	ED/O		thor	ath (Check only o		-		
ding Phy h. After this funeral d	I	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Yeer)	ER/Outpatier 28b. Time o Injury	t 28c. inj	4   Nursing	Home 5 Residence 1 Residence 1			/)	
To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 390 Blood of Injury - At h	ome, farm, str y)	reet, factory, office	9	28f. Location (S City or Tox	Street and wn, State)	Number or Rura	l Route Num	ber,
e Hospita 124 hours e Funera fetely fille	edical C	29a. Certifier 1X Certifying I (Check only one)	Physician: To the best of my known aminer: On the basis of examination and manner stated.	owledge, deat ition and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) a date and p	nd manner as st lace, and due to	ated. the cause(s	:)
To th within To th compl	Me	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date	signed (Month, I	Dey, Year)	
(2)		The	DOY, M.D.		D00	60552		4-13	<b>-</b> 04		
(3)	1	20. Name and address of person wh	V			cle Carn	nantown.	Md.	20874		
S	tate	Steven Fong, M. 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature _		CIC, GEIL					
Regis		APR 2 7 200	4 Marie 16	1200	61						

Deceder Name (First, Michiel, Last)   PERRY Jr.   2 Date of Death Day April 1 20 2004   23:30		1 - For State Registrar		State of	Marylar		artment <i>rtificate</i>				giene	2001	151
PRINCE CORDET'S HOSPITAL CONTROL CONTROL CONTROL OF A Seating Name of ord ministric, phe situate and number)  **FRINCE CORDET'S HOSPITAL CONTROL CONTR			Middle Last	*1			rimouto	0, 000	407			- 00 "	
Legislation of the control of present and con	Physician				DDV -					Month	Day		
PRINCE GEORGE'S HOSPITAL  PRINCE GEORGE'S NAME STATE   2 April 1979, and bothomy.   Whom   1979   19	/Medical					r.							23:30
5. Secial Security Number    Secial Security Number   Second Security Number   Security Number   Security Number   Security Number   Security Number   Security Number   S	Examiner						4b. City, To	own, or Loca	ation of Death		4c. Cour	nty of Deeth	
8. Secial Security Number   Second Security Nu					.L						PRIN	CE GEO	ORGE 'S
10   5   1943   Washington   100 County	Funeral									8. Date of Birt	h		
100 Days   100 Days	Director	5.78-58-3853	الا	XW ZUF	60	Yrs.					1943		
Solician   Security													
Security   Security	P P		ounty		10c. Ci	ity, Town or Lo	ocation					1	
Security   Security	cto	MD	rince	George	's	Lanha	m						1 ☑ Yes 2 ☐
23a Part   Entret the distribution of the cause of the	lre lre	10e. Street and Number						ode			10g. Citizen o	f What Cour	itry?
23a Part   Enter the distribution on completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	38	5/02 Ellowh	10 C++	****			,	0706			•••		
23a Part   Enter the distribute or complications that caused the death. Do not enser the mode of dying, such as cardiac or respiratory arrest.	ms 2	11. Marital Status	TE DEL	12. Was Deced	dent Ever in U	J.S. 13.			ic Origin? (Sc	ecify Yes or No-			an Indian.
Security   Security	5 F	1 Never Married 2	XMarried				If Yes, specify	y Cuban, Me	xican, Puerto	Rican, etc.)	В		
23a Part   Enter the distribute or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	by I	* 3 ☐ Widowed 4 ☐ Dr		If Yes, Give	9		1 ☐ Yes 21	No Sp	ecify:		Spec	sify: B1	.ack
23a Part   Enter the distribution on completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	ed a	15 De	codent's Edi			16a Daca	dont's Heyal	Occupation			40h Kind of	D	4
Solician   Security	let die	(Specify only	highest grad	le completed)		(Give	kind of work	done during	most of work	ing	16b. Kind of	Business/inc	dustry
23a Part   Enter the distribute or complications that caused the death. Do not enser the mode of dying, such as cardiac or respiratory arrest.	m m m	Elementary/Secondary (	)-12)	College (1-	4or 5+)			retired)					
23a Part   Enter the distribution on completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	S F P S					For	eman						
23a Part   Enter the distribution on completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	Se Se Se Se Se Se Se Se Se Se Se Se Se S			_				18. A				ame)	
23a Part, Effect the distribution on cause on sech line.	To street	Francis Lloy	d Perr	y Sr.					Beati	cice But	ler		
23a Part   Enter the distribution on completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	e de la composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della comp		ationship (Ty	ype, Print)		19b. Mailir	ng Address (S	Street and N	umber or Rui	al Route Numbe	r, City or Tow	n, State, Zip	Code)
23a Part, Effect the distribution on cause on sech line.	27 I	Ernestine P	erry/W	/ife		5403	Eller	bie S	treet	Lanham.	Marvla	and 20	706
23a Part   Enter the distribution on completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	othe	20a. Method of Disposition				Place of Dispo	sition (Name	of					
23a Part   Enter the distribution on completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	7 ± 5 ×				tate	•			1.10				
23a Part   Enter the distribution on completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	rtan Diuri				$\frac{L}{L}$				The state of the second	V - D Q - F - T - C - C - C - C - C - C - C - C - C			
23a Part   Enter the distribution on completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	mpo iny ii	21. Signature of Funeral 2	JIVICO LICONS	ee					J	.B. Jen	kins F	unera.	L Home
Section   Final Register   Carcinoma of Lung   Carcinoma of Lung   Due to (or as a consequence of):	JE & G	61	9									ryland	20705
Immediate Cause (Final death)   Carcinoma of Lung		23a. Part1. Enter the dis	e, or compli	ications that can	used the deat	th. Do not ent	er the mode	of dying, suc	h as cardiac	or respiratory ari	est,		Approximate
Due to (or as a consequence of):    Due to (or as a consequence of):	vsician	Immediate Cause (Final	, , , , ,			of Tune							Onset and Deat
Sequentially list conditions cause. Enter Underlying Cause (five search of the conditions)  Sequentially list conditions cause. Enter Underlying Cause (five search of the conditions)  Sequentially list conditions cause. Enter Underlying Cause (five search of the conditions)  Sequentially list conditions (asset five search of the conditions)  Sequentially list conditions (asset five search of the conditions)  Due to (or as a consequence of):  d. d. d. d. d. d. d. d. d. d. d. d. d. d		resulting in death)	-	a			3						
Due to (or as a consequence of):    Security of the past 12 months?   1	aminer			Due to (o	as a conseq	(derice or).							
Due to (or as a consequence of):    Security of the control of the		Sequentially list conditions	l l	Due to /o	or as a consecu	tuence of):							
Due to (or as a consequence of):    Security of the control of the	Jn Sit	cause. Enter Underlying	- ₹	246 10 (0	1 43 4 001304	delice of.							
FEMALE:   23c. If yes, outcome of pregnancy   1   1   1   2   Fetal death   3   Ectopic pregnancy   1   1   1   2   1   1   2   1   2   3   3   3   3   3   3   3   3   3	and -tran	that initiated events	c	c									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of deat 1 2 24e. Was an autopsy performed cause of deat 2 24e. Was an autopsy performed 1 29e. Place of Death (Check only one)  25e. Was case referred to medical examiner?  1	urial urial	The state of the s		Due to (o	r as a conseq	luence or):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  239. Did tobacco use contribute to the cause of death 1	he b	*		d									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  239. Did tobacco use contribute to the cause of deat 1 2 Yes 2 No 3 Probably 4 Unking 1 Yes 2 No 3 Probably 4 Unking 1 Yes 2 No 3 Probably 4 Unking 1 Yes 2 No No No No No No No No No No No No No	as t	LIE SELLIN S				777				_			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  239. Did tobacco use contribute to the cause of deat 1 2 Yes 2 No 3 Probably 4 Unking 1 Yes 2 No 3 Probably 4 Unking 1 Yes 2 No 3 Probably 4 Unking 1 Yes 2 No No No No No No No No No No No No No	use use	23b. Was decedent pregna	int 2	3c. If yes, outco	ome of pregna		15-1				23d. D	ate of delive	ry
239. Did tobacco use contribute to the cause of deat    1	d for	in the past 12 months	?	4□Pregnar	nt at time of d						N	lonth	Day Year
23. Did tobacco use contribute to the cause of deat    1	y the	9 Unknown		9□ Unknow	vn			,,					
1   Yes   2   No   3   Probably   4   Unkilder   1   Yes   2   No   3   Probably   4   Unkilder   1   Yes   2   No   3   Probably   4   Unkilder   1   Yes   2   No   3   Probably   4   Unkilder   1   Yes   2   No   3   Probably   4   Unkilder   1   Yes   2   No   3   Probably   4   Unkilder   1   Yes   2   No   3   Probably   4   Unkilder   1   Yes   2   No   3   Probably   4   Unkilder   1   Yes   2   No   3   Probably   4   Unkilder   1   Yes   2   No   1   Yes	deta deta	Part II. Other significant cr	nditions cor	ntributing to dea	ath but not res	ulting in the u	nderlying cau	se given in F	Part I	23e Did to	bacco use co	ntribute to th	a cause of death
24a. Was an autopsy performed?   24b. Were autopsy findings ava prior to completion of cause death?   1	0 0					•	, . ,	- · · · · · · · · · · · · · · · · · · ·					
25. Was case referred to medical examiner of Death 1 Normal Properties and Number or Rural Route Number, 28d. Normal Properties 25d. Norm	een nouk									, X	3 2 110	3 🗆 🗆	ioly 4 DONKI
25. Was case referred to medical examiner?  1	2 st											. Were autop	sy findings avail
25. Was case referred to medical examiner?  1   Yes 2   No	age mo									perform	ńed?	death?	
1   Yes   2   No   Name and address of person who completed cause of death (Item 23a) (Type, Print)   1   Yes   2   No   Name and address of person who completed cause of death (Item 23a) (Type, Print)   1   Yes   2   No   Name and address of person who completed cause of death (Item 23a) (Type, Print)   1   Yes   2   No   Name and address of person who completed cause of death (Item 23a) (Type, Print)   1   Yes   2   No   Name and address of person who completed cause of death (Item 23a) (Type, Print)   1   Yes   2   No   1		25 Was case referred to n	edical						N (D)			1 Li Yes	2 <u>X</u> 1 No
Second Part   Second Part	or. p	examiner?	100	lospital:				04					
Section   Continuous   Contin	rector, pa	1 Tes 2X No		1 (XI lut				4					)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	this certifical director.		ending	(Month,	, Day Year)			. Injury at Work?		28d. Describe ho	w injury occu	irred	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	this certifical director.	27. Manner of Death	ivestigation				М	1 🗀 Yes	2 🗌 No				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and date and address of person who completed cause of death (Item 23a) (Type, Print)	this certifical director.	27. Manner of Death  1 X Natural 5 F 2 Accident	_	28e. Place o	of Injury - At ho	ome, farm, str	eet, factory, o	office		28f. Location (St	reet and Num	ber or Rural	Route Number,
29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	this certifical director.	27. Manner of Death 1 X Natural 5 F 2 Accident ii 3 Suicide 6	Could not be	building	y, (-p)	,,				Only of Tolli	, Olaib)		
5) Tour of Transport 10 5891 4/23/04	this certifical director.	27. Manner of Death 1 X Natural 5 F 2 Accident ii 3 Suicide 6	Could not be	building									
5) Togas in Front and 105891 4/23/04	this certifical director.	27. Manner of Death  1 X Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier  1 X Ce	Could not be letermined	sician: To the b	est of my kno	wledge, death	occurred at	the time, dat	e and place.	and due to the ca	ause(s) and m	anner as sta	ited
5) Tour of Transport 10 5891 4/23/04	Funder Director: After this certifical only the funderal director of filled in by the funderal director or filled in by the funderal director or filled in by the funderal director or filled in the funderal or filled in the fun	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 6 C 4 Homicide	Could not be letermined	sician: To the b	sis of examina	wledge, death	occurred at restigation, in	the time, dat my opinion,	e and place, death occurr	and due to the ca	ause(s) and mate and place	nanner as sta , and due to	ited. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	unerel Director: After this certifiely filled in by the funeral director cal Certification; To Be	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	Could not be letermined rtifying Phys dicat Examir	sician: To the b	sis of examina	wledge, death tion and/or inv	estigation, in	my opinion,	death occurr	ed at the time, d	ate and place	, and due to	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Funder Director: After this certifical only the funderal director of filled in by the funderal director or filled in by the funderal director or filled in by the funderal director or filled in the funderal or filled in the fun	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	Could not be letermined rtifying Phys dicat Examir	sician: To the b ner: On the bas and manne	sis of examina	ition and/or inv	estigation, in	my opinion,	death occurr	ed at the time, d	ate and place	, and due to	the cause(s)
Rodger Ingham M. C. 6510 Kenilworth Avenue # 2400 Riverdale, Maryland 20735	a nous arrendeam.  Funerel Director: After this certified in by the funeral director.  Ical Certification; To Be	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of C	could not be letermined  rtifying Physical Examire certifier	sician: To the base and manner	er stated.	tion and/or inv	29c. L	my opinion,	death occurr	ed at the time, d	ate and place	, and due to	the cause(s)
	Thous are result.  Substituted birector: After this certified in by the funeral director.  Cal Certification; To Be	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of cone)  30. Name and address of pi	could not be letermined  rtifying Physical Examinertifier  ertifier  arson who co	sician: To the biner: On the bas and manner	of death (Item	n 23a) (Type,	29c. L	my opinion.	death occurr ber 891	ed at the time, d	ate and place  9d. Date sign  4/2	, and due to ed (Month, E 3/OXL	the cause(s)

DHMH 17 Rev 1/2001

ORIGINAL

1	,		1_ For State	State of Maryland / D	epartment of Health and N	Mental Hygiene	
_			Registrar		Certificate of Death	Reg. No. 20	104 15476
	Physici	an	Decedent's Name (First, Middle, Las	•		Date of Death     Month Day	3. Time of Death
W	/Medi		Margaret C. Qua			May 7 20	- M
	Examir	ner	4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Death	4c. County	of Death
	(4) 内		13705 Cecil Ave		Cresaptown	Al	legany
В	Funeral		5. Social Security Number 6. Se	744 of 1976	Months Days Hours Min.	8. Date of Birth (Month, Day, Yeer)	Birthplece (State or Foreign Country)
6.	Director		213-22-3323	□ M 2LAF   87 Y	rs.	July 14,1916	Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Manyl f sho	0	Maryland Alleg	any Cresa	ntorm		1 ☐ Yes 2X No
	28a-	ect	10e. Street and Number	any cresa	10f. Zip Code	10g. Citizen of V	What Country?
	with Sa or	ā	13705 Cecil Av	е	21502	USA	That Gounty:
	J within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-1 show the Medical Examinar intell by multiled at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.			e - American Indian,
(0	riter	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🐼 No	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.) Blac	ck, White, etc.
93	urs a	ğ	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	Specify	White
9	72 ho	Completed	15. Decedent's Ed	ucation 16a. [	Decedent's Usual Occupation	16b. Kind of Bu	usiness/Industry
215	within 7 ene. than "r	ple	(Specify only highest grad	College (1-4or 5+)	Give kind of work done during most of work life. DO NOT use retired)	ing	
21	filed wi Hygien ther th	S	12		Homemaker	Own	Home
b	be filed itał Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maiden Surnam	ne)
yla	should to and Ment to marked umatic e	2	Pietro Prato		Michel	ina Sicoli	
Maryland 21215-0036	sho and is m		19a. Informant's Name/Relationship (T	/pe, Print) 19b.	Mailing Address (Street and Number or Run	al Route Number, City or Town,	State, Zip Code)
	1 and 2 Health em 27		Elizabeth Rotri	ick-Daughter 13	800 Blue Jay Dr.	, Cumberland	MD 21502
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	crematory or other place) May	20c. Location - 20 4	City or Town, Stete
Ē	2 2 2 2		' 4 ☐ Donation 5 ☐ Other (Specify,	Rest I	awn Mausoleum	F-1	e, MD 21502
<u>sa</u>	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens		22 Name and Address of Facility Haier Funeral S	ervice DA	-, 2.002
_	40 E E G	X 97	Douglas S	Harry	1302 National H	wy. LaValo	MD 21502
H.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do no	1302 National Hi	or respiratory arrest,	Approximate Interval Between
	Physician	i i	disease or condition	Metrstat.	ic Breast CA		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	i).		
8	Cxammer		Sequentially list conditions.	b			
7	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	):		
(2)	and trans	cam	that initiated events resulting in death) Last	c			
760,	ate be executed hysician and he burial-transit			Due to (or as a consequence of	):		
687	cate l	dlcal		d			
	ertifical ding phy se as th	/Me	IF FEMALE:	220. If you guitages of programs			
Вох	atten atten for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy	23d. Date	e of delivery oth Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)		
	The law requires that the death certifica te has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not resulting in t	he underlying cause given in Part I	23a. Did tobacco usa contr	ibute to the cause of death?
ds,	signed det		-	<b>3</b>			3 ☐ Probably 4 ☐ Unknown
Š	v requir been s should	ete					
Vital Records,	has has	Completed				autopsy p	Vere autopsy findings available rior to completion of cause of eath?
<u>_</u>							Yes 2 No
<b>\rightarrow</b>	iciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death		
o	Phys this ral dii	2	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outp  28a. Date of Injury 28b. Tin		me 5 Residence 6 Othe	
Division of	Attending Physician: r death. sctor: After this certific by the funeral director.	Certification:	1 Natural 5 ☐ Pending	(Month, Day Year) Inju		28d. Describe how injury occurre	90
<u>s</u>	deat ctor: y the	Ica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm		28f. Location (Street and Numbe	ar as Rusal Route Number
<u>≤</u>	after Dire	erti	4 Homicide determined	building, etc. (Specify)	i, sireet, ractory, critice	City or Town, State)	or noral noble Northber,
	spita sours neral		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge.	death occurred at the time, date and place, a	and due to the cause(s) and mar	nor as stated
	• Ho 24 h • Fui e Fui	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and/ and manner stated.	or investigation, in my opinion, death occurre	ad at the time, date and place, a	nd due to the cause(s)
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier		29c. License number	29d. Date signed	(Month, Day, Year)
			Ant Mes	no Vamos a	D. 59407	5/10/	24
	6	1	30. Name and address of person why co	ompleted cause Heath (Item 23a) (Tr	ype, Print)	2/1-/0	
	V)		1 21 2126		ational Hory L	a Vale MO Z	21502
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature			·
	Registr	ar	MAY 1	3 2004	I Smiles .		

	To the To the compl	Me
R		
	Sta	te

			1 - State Registra-Amend#31.Per VR PCC cr	Certificate of Death	Reg. No. 2004 1547
	Physici	an	1. Decedent's Name (First, Middle, Last)	A 7	2. Date of Death Month Day Year 3. Time of Death
9	/Medic		CLARICE, RICHARDSON		0 4 21 200 4 02:25 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	
	-		Prince Georges Hospital Cen. 5. Social Security Number 6. Sex 7. Age (In yrs. last.		Prince Georges  8. Date of Birth  9. Birthplece (State or Foreign
	Funeral Director		579-72-6854 1 M 2 XF 51  Usual Residence of Decedent	Yrs. Months Days Hours Min.	
	land land			own or Location	10d. Inside City Limits
	death with the Maryland rms 23a or 28e-f show r nust be notified at	tor	MD Prince Georges	Brentwood	1 Yes 2 □ No
	the north	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	3a o		4525 41st Ave.	20722	U.S.A.
	ms 2	Funeral	11. Maritat Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp It Yes, specify Cuban, Mexican, Puerto	
50	be filed within 72 hours after death with the Marylan tal Hygiene d other than "naturel", or items 23s or 28e-1 show event, the Medical Exeminer must be notified at	by Fu	1 Never Married 2 Marned 1 Yes, Give 13 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	to Rican, etc.)  Black, White, etc.  Specify:  Black
ş	2 hou	Completed	15. Decedent's Education	6a. Decedent's Usual Occupation	16b. Kind of Business/Industry
7	nin 7	ed (	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ixing
Maryland 21215-0036	filed wil Hygien other th	Con		Child Care Provide	
	be file	Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden Sumame)
<u>X</u>	Men Men arke	70	William Draughn		Mattie Belle Saunders
Jai	2 se se se se se se se se se se se se se				ural Route Number, City or Town, State, Zip Code) #23 Silver Spring, Md.
_	s 1 and of Health item 27 other to			of Disposition (Name of	Dete 20c. Location - City or Town, State
0			1 ☐ Buriat 2X Cremation 3 ☐ Removal from State	erdale Pk.Crem May	200. 2000.000
	t. Pa rtmen rtant: njury		4 Boundary 8 Bound (openny)		
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licenses		unt Funeral Home
			23a. Pert1, Enter the disease, or complications that caused the death. D		N.W.Wash.D.C.20011 c or respiratory arrest, Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1 2 1 1	Interval Between Onset and Death
	Physician /Medical		disease or condition a. Creaco My	heart fartiere	
	Examiner		Due to (or at a consequence		
P		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	Cardany o pattu	
	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Outony discas	ar .
,	exection and ital-tra	Еха	resulting in death) Last  Due to (or as a consequence	e ot):	
68760	icate be executed physician and s the burial-transit	cal	d		
_	tifica ng ph as th	Medical			
ŏ	eath certific attending pl	*	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dec	ath 3 Ectopic pregnancy	23d. Date of delivery
מ	deal	slois	1 Yes 2 No 4 Pregnant at time of death		Month Day Year
o.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician	9 Unknown		
	es th igned	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ב	bluo ben s	ted	- Asima exacts and		1 Yes 2 No 3 Probably 4 Unknown
<b>Records</b> ,	e law r has be je 2 sh	Completed	- Ventrienar arrythm	ia	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
ĭ	The ate h page	Con	J		performed? death? 1 ☐ Yes 22 No 1 ☐ Yes 2 ☐ No
Vita	sicien: The l certificate ha	Be (	25. Was case reterred to medical examiner?		ath (Check only one)
	Physi this c	9	1 ☐ Yes 200 No Hospital: 1 2 Inpatient 2 ☐ ER/		Home 5 Residence 6 Other (Specify)
<u>_</u>	ding P. h. After t	lon:	1 Natural 5 □ Pending (Month, Day Yeer)	b. Time of linjury at Work?	28d. Describe how injury occurred
<u>s</u>	tend feath tor: /	cat	2 Accident investigation	M 1 Yes 2 No	201   2
DIVISION OF	or A after ( Direc in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	, raim, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
_	pitel ours s eral l		29a. Certifier X Certifying Physician: To the best of my knowled	dge death occurred at the time date and along	and due to the cause(s) and manner and the
	24 hr Fun etely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occur	s, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	->+0		I fabla khali	Achoine D6033	59 4/22/04
>	(1)		30. Name and address of person who completed cause of death (Item 23)	( Morall 191)	
_			Khalid H. Ashai		al Dr.Cheverly.MD.@)&*%

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

			For State Registrar			Health and M	ental Hygi	ene g. No. 2004	. 0 , 10
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last)     R.C. Russell  4a. Fecility Name (If not institution, give	Robinson	4b. City, Town,	or Location of Death	2. Date of Death Month April	Day Year 25,2004 4c. County of Death	
	Funeral Director		Prince Georges Ho 5. Social Security Number 246-18-0151  Usual Residence of Decedent	spita1 7. Age (In yrs. last birthda M 2□F 79 Yrs.	Chever (1) If Under 1 Year (Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan . 24, 1	Prince Go 9. Birth Cor .925 Nort	Borges Iplace (State or Foreign Unitry) Th Carolina
	th the Maryland or 28a-f show	Director	10a. State 10b. County  MD. Prince G  10e. Street and Number	eorges Seat Ple			10	g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ No untry?
36	d within 72 hours after death with the Maryland Jiene. r then "natural", or items 23a or 28a-f show the Madical Examinar must be notified at	by Funeral D	304 69th Place  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 [3Yes 2 □ No If Yes, Give Year or Dates;	207 de la 207 d	Hispanic Origin? (Specian, Mexican, Puerto F		14. Race - Amer Black, White	
Maryland 21215-0036	J within jiene. r then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Dec (Giv   G	edent's Usual Occup le kind of work done DO NOT use retire DIMAN	during most of workind)	g	6b. Kind of Business/li Constructi	ndustry
ryland	ed at at	To Be	17. Father's Name (First, Middle, Last)  Claude Robinson  19a. Informant's Name/Relationship (Ty	na Print) 19h Mai	ling Address /Street		ie Reddi	,	in Code
	ges 1 and 2 s t of Health an If item 27 is or other treu		Saundria Parker(Dau  20a. Method of Disposition  1 🌣 Burial 2 □ Cremation 3 □ R	ughter) 5840	Cameron I	Run Terr.#4	433,Alex		gin <u>ia 22303</u>
Baltimore,	permit. Pag Department Important: I eny injury c		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	90	22. Name and Addre	Lewi	ls Funer		•
AÎ,	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not ele cause on each line.  Due to (or as a consequence of):	pofic	Shock			Approximate Interval Between Onset and Death
8/60,	icate be executed physician and sthe burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	nary	fice	ct in	i- efection	
P.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be delached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnanc: □ Other (specify)	у		23d. Date of deliv Month	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	stributing to death but not resulting in the	underlying cause giv	ven in Part I.	1	cco use contribute to t	he cause of death? bably 4 Stonknown
Vital Records,		Completed	06 Wo				24a. Was an autopsy performe 1 Yes 2	prior to co	opsy findings available impletion of cause of
	Phys this ral dir	n: To Be	25. Was case referred to medical examiner?  1 Yes 2 No H  27. Manner of Death  1 Natural 5 Pending	ospital: 1 Denpatient 2 ER/Outpatie		y at 28		ce 6 Other (Special	<b>y</b> )
Division of	or Atten ifter deal Director. In by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 🗆	Yes 2 □ No	8f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	one)	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	nvestigation, in my o	pinion, death occurred	d at the time, date	and place, and due to	o the cause(s)
	Vith with Com	Σ	29b. Signature at title of certifier  30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	29c. Licens			Date signed (Month, 4/27/	Day, Year) 2004 M) 2076,
_	Sta		DY CRITA K-S 31. Date filed (Month, Day, Year) ADD 2. 9. 2004	HAH 7350 VC	au Dus	ENRU-	#220	Layrel	M)2070

		-		gpe or Print in Black in State of Maryland / Depa Cei		lental Hygie	_	15477
	*		Decedent's Name (First, Middle, Last)			2. Dale of Death		3. Time of Death
	Physicia		Michael Alan R	ietzler		April 28	3, 2004 Yeer	4:09 p M
	/Medic Examin	_	4a. Fecility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		4c. County of Deeth	
			8123 Gavin Street		New Carrollto	n	Prince	George's
	Funeral Director		212-80-9009	7. Âge (In yrs. last binthday)  7. Âge (In yrs. last binthday)  7. Âge (In yrs. last binthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Dey, ) Feb. 11,		plece (Stete or Foreign intry) shington, dC
	and *	}	Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Aaryl f sho	ō	MD Prince (	George's New Ca	rrollton			1 TYes 2 □ No
	the 1	Director	10e, Street and Number		10f. Zip Code	109	g. Citizen of Whal Cou	intry?
	3a or		8123 Gavin Street		20784		USA	
	ms 2	by Funeral	11. Marital Status	Was Decedent Ever in U.S. 13. 1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer	
9	or Its	Ē	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No	1 ☐ Yes 2 ☒ No Specify:	rican, etc.)	Black, White	White
8	ral', c		3 Widowed 4 Divorced	Year or Dates:	TEL 165 212 NO Specify.		Specify:	WIII CC
5-0	72 h	Completed	15. Decedeni's Educ (Specify only highest grade	completed) (Give	denl's Usual Occupation kind of work done during most of work	ing 16	6b. Kind of Business/li	ndustry
2	ithin ne. hen.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		0	- <b>.</b>
2	filed within 72 hours after death with the Maryland Hygiene. After then "natural", or thams 23a or 28a-f show ont, the Medical Examiner must be notified at	ပိ	12 17. Father's Name (First, Middle, Last)	r	ipe Installer	e (First, Middle, Ma	Construct	1011
and	ntal hed of	Be	Joachim Martin R	ietzler		n Anne Re	,	
Ž	hould d Me mark matic	<b>1</b> 0	19a. Informant's Name/Relationship (Typ		ng Address (Street and Number or Run			n Code)
<u>8</u>	d 2 s th an th an trau		Martin Rietzler -		Gavin Street, Ne			20784
ė	1 an Heal Hem 2		20a. Method of Disposition	20b. Place of Dispo	esition (Name of		C. Location - City or T	
JO L	ages ant of it: If ii		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		matory or other place) tan Crematory4/30,	/2004 A	lexandria,	VA
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Itams 23a or 28a-1 show eny injury or other traumatic event, the Medical Examiner must be notified at 90ce.		21. Signature of Funeral Service	22	2. Name and Address of Facility	acable Ev	neral Home	D A
Ba	Departiment Department		Infusta V	May 4	739 Baltimore Ave			
×	Physician		shock, or heart failure. List only on Immediate Cause (Final	cations that caused the deeth. Do not ent e cause on each line. Gunshot wound to		or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as e consequence of):				
B	Examiner							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Dies to (or as a consequence of):				
	cuted nd ransi	Examiner	that initiated events c					
760,	le be executed ysician and e burial-transit	EX	resulting in death) Last	Due to (or as a consequence of):				
876	cate b physic s the b	dical	d					
x 68	death certificate le attending phys ed for use as the	Me	IF FEMALE:	3c. If yes, oulcome of pregnancy				
Вох	attence for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 □	Ectopic pregnancy Other (specify)		23d. Date of delin	ery Day Year
o.	the de	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	Other (specify)			
Δ.	that the de ed by the detached		Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
of Vital Records,	88 60	d by				1 🗆 Yes	2K□No 3□Pro	bably 4 Unknown
S	w require been si should I	Completed				24a. Was an	24b. Were aut	opsy findings available
Re	he lav e has	E C				autopsy performe	prior to co	ompletion of cause of
ā	ificate	ပိ	25. Was case referred to medical		26 Place of Deat	1 ☐ Yes 2 h (Check only one)	ŽNo 1 ☐ Yes	2   No
5	Physician: this certific ral director,	0 8	examiner?	ospital:	Othor		ce 6 ☐Other (Spec	fv)
of	g Phy er this	Į.	27. Manner of Death	28a. Date of Injury 28b. Time of		28d. Describe how		,,
ion	Attending r death.	atio	1 ☐ Natural 5 ☐ Pending investigation	April 28,2004 1600		Shot hims	self in hea	ad
Division	Attendi	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stre	et and Number or Rui State) 8123 Ga	al Route Number,
ā	s after el Dire	Certification;	T I TOURING	Hon	ne		llton, MD	20784
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 ☐ Certifying Physical (Check only one)	sician: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, deeth occur	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month	Day, Year)
1			- Salarada	gusto to	15005592	7	And:	50, 2004
/	(1)		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	Print)		/	1
			SALVADON 3/	voter, 3001 Bo	spital Drivy	Chevrl	4 MARI	14wd
90	Sta Regist		31. Date filed (Month, Day, Year)  APR 3 0 2004	32. Registrar's Signature	w		, ,	

			1 ← For State Registrer		Maryland	d / Dep <i>Ce</i>	artmen rtificate	t of H	ealth a Death	and M	ental Hyg	giene Reg. No. 2 (	004	15478
Г	Physici	an	1. Decedent's Name (First, Middle Rosario M. Ri								2. Date of Dea Month	Day	Year	3. Time of Death
4	/Medic Examir		4a. Facility Name (If not institution		iber)		4b. City,	Town, or	Location of	of Death	APRIL		2004 nty of Death	
	Lxaiiii		Doctor's Comm	-			Lanl							eorges
	Funeral		5. Social Security Number 126-24-5754	6. Sex 1	7. Age (In yrs. la		If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)		place (State or Foreign
	Director		Usual Residence of Decedent		73	Yrs.					10-07-	-1930		rto Rico
	ehow		10a. State 10b. County		10c. City	, Town or Lo	ocation						1	10d. Inside City Limits
	Ba-fe	Director	MD Prince	e Georges	La	nham								1 X Yes 2 □ No
	with th	Dire	10e. Street and Number 6314 93rd Ave.				10f. Zip				1	10g. Citizen d		ntry?
	leath ns 23	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S	S. 13.		0706	snanic Orio	nin? (Sne	cify Ves or No-		SA ace - Americ	can Indian
36	172 hours after death with the Maryland "neturel", or items 23a or 28a-f ehow clical Examiner must be multiped at	by Fun	1 ☐ Never Married 2 🛣 Marr	Armed Ford ied 1 ☐ Yes : If Yes, Give	ces? 2 <b>∑</b> No		If Yes, spec		Specify:	, Puerto F	cify Yes or No- lican, etc.)		lack, White,	etc.
00	thour	ed p	3 ☐ Widowed 4 ☐ Divorced	Year or Da	tes:	16a. Dece	dent's Usua	Occupa	tion			16b. Kind of		
215		Completed	(Specify only highest Elementary/Secondary (0-12)		40r 5+)	(Give	kind of wor DO NOT us	k done d e retired,	uring most	of workin	g	TOD. KAILO OF	DUSINESSIN	dustry
21	e filed within at Hygiene. other than '	Сош	12th		40, 37)	House	ewife					Pri	vate	
Baltimore, Maryland 21215-0036	should be fill and Mental H marked oth	To Be	17. Father's Name (First, Middle, Thomas Rivera	Last)			\$ .				(First, Middle, i Lna Geig		ame)	
ary		۲	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address	(Street a			Route Number		m, State, Zip	Code)
Σ	and 2 ealth a n 27 le		James W. Rusher	/ Husband		6314	93rd	Ave	, Lai	nham,	MD 20	706		
ore	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition  1 XBurial 2 Cremation	3 □Removal from S	tate ce	ace of Dispo metery, crei	natory`or ot	her place				20c. Location		
Ħ	rtmer rtant rtant njury		21. Signature of Fun I Service		Mar	yland			,					Maryland
Ba	Depa Impo any is	(	21. Signature of Funda Service	Licensee			2. Name and 7474 I			0	. Jenki Landove	ins Fur er, Md	neral • 207	
W			snock, or neart failure. List	complications that ea only one cause on ea	used the death. ch line.	. Do not ent	-				respiratory arre	est,		Approximate Interval Between
71	Pnysician /Medical		disease or condition resulting in death)	shock, or heart failure. List only one cause on each line.  ediate Cause (Final ase or condition (Interval Between Onset and Death 20 M) AV TO (Interval Between										
	Examiner			Due to (or as a consequence of):										
	P ≅	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (o	ence of):									
	ecuter and rrans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	r as a conseque	2222 241:								
8760,	cate be executed by sician and the burial-transit			Due 10 (0	i as a conseque	ance or).								
9	ifficate g phys as the	edlo		0.										
Вох	death certifice e attending ph d for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnan		Ectopic pre	onancy				23d. D	ate of delive	,
		Physician/Medical	in the past 12 months? 1 □ Yes 2 🏿 No 9 □ Unknown		nt at time of dea		Other (spe					N	lonth	Day Year
, P.O.	requires that the dieen signed by the		Part II. Other significant condition	ns contributing to dea	ith but not resul	ting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use co	ntribute to th	e cause of death?
rds	w requires that been signed be should be det	ed by	DIABETE	's mall	TUS						1 □ Ye	s 2DNo	3 🗌 Proba	ably 4 □Unknown
eco	2 sl	Completed	PERIPHRA	L NEVA	20 PAT	HY	_			_	24a. Was ar	n 24b	. Were autor	psy findings available
E E	ate pag	Con									perform	ned?	death?	2□ No
Vita Ita	Phyeician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor			Check onl one			
of	Physical dispersion	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		R/Outpatien 28b. Time of		c. Injury	4   14013		e 5 🗌 Reside			)
ion	Attending I or death. ector: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month,	Day Year)	Injury	М	Work'	es 2∐N			injury cood		
Division of Vital Records	I or Attencafter death Director: I in by the	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 286. Place o	f Injury - At hom g, etc. (Specify)	ne, farm, str	eet, factory,	office		28	If. Location (Str City or Town	reet and Num	ber or Rural	Route Number,
Ω	Hospital of the safe of the sa		29a. Certifier 1 Certifyin	District Town			·							
		edical	(Check only 2 Medicel I	g Physicien: To the b examiner: On the bas and manne	is of examination or stated.	neage, death on and/or inv	estigation,	t the time in my opi	e, date and nion, death	place, an occurred	id due to the ca I at the time, da	use(s) and mate and place	nanner as sta , and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Cu-			29c.	License	number	77	29	d. Date sign	ed (Month, E	Day, Year)
1								, 4	2 1	//		4.2	-1.0	7
)(	5/		A. DASHOTTO	PR, MP	7207	23a) (Type, 1	Print)	PARI	& MA	7 4	A, GREE	FUBEL	I mo	1-20770
	Sta Registra		29a. Certifier (Check only one)  29b. Signature and title of certifier where the control of the control of the certifier of the control of the certifier of the	32. Reg	gistrar's Signatu	Cool	e e		/					

		1 - For State Registrar		Maryland	d / Depa <i>Cei</i>	artmen rtificate	t of H	ealth a Death	and M		gien Reg. N	e2004	15479
Physic /Med Exam	ical	1. Decedent's Name (First, Middle,  ETHEL  4a. Facility Name (If not institution,  Heartland Heal	ROBIN give street and number	er)		4b. City,		Location of	of Death	2. Date of De Month April	18,	ay Year 2004 c. County of Death rince Ge	
Funera Director				Age (In yrs. Ia		If Under Months	1 Year	If Under	Min.	8. Date of Biri (Month, Da Nov. 1	th v, Year		nplace (State or Foreign
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar matche notified at once.	To Be Completed by Funeral Director	10a. State  D.C.  10e. Street and Number 4908 Kansas Ave 11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced  (Specify only highest Elementary/Secondary (0-12)  11th  17. Father's Name (First, Middle, L George Colbert  19a. Informant's Name/Relationsh	12. Was Dacede Armed Force 1   Yes   2   If Yes Give Year or Date s Education grade completed)  College (1-4c) ast)	Was int Ever in U.S is? in No s:	16a. Deced (Give life.) Dome	On 10f. Zip 2  Was Deced f Yes, spec 11 Yes 2  dent's Usua kind of wor OO NOT us Stic	ent of His fry Cubai  C	spanic Original Mexican Specify:  tition uning most er  18. Mothe Mart	of working or's Name ha or or Rural	city Yes or No Rican, etc.)	U. S. 16b. H. Maidell Maidell Pr., City	Kind of Business/I Private n Sumame) or Town, State, Z	ican Indian, o, etc. ack ndustry
Baltimore, In permit. Pages 1 and Department of Health Important: If item 27 any injury or other 1 once.		Gladys Gartrell  20a. Method of Disposition  1 Kaurial 2 Cremation  4 Donation 5 Other (Sp  21. Signature of Funeral Service L	3 □Removal from Sta	te Cel	mony 22	Mem Pl Name and	ner place k. d Addres:	4/24 s of Facility	/04 John		Lan Jenk	20011 ocation - City or I ndover, A cins Inc.	<u>1</u> D.
58760, icate be executed Physician and physician and street be unial-transit	ical Examiner	23a. Part. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. And the Due to (or a Due to (or a c.		ence of):					NIS & T		2	Approximate Interval Between Onset and Death
O. Box ( ne death certif the attending thed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal of at time of dea	death 3□	A Ectopic pre Other (spe	ognancy ocify)					23d. Date of delive	very Day Year
cords, P. (w requires that the bear signed by should be detact	þ	Part II. Other significant condition	s contributing to death	but not result	iting in the ur	DEU	use give	n in Part I.	<u>'S</u>	1 🗆 Y	'es 2	No 3□Pro	the cause of death? bably 4 □Unknown
Vital Records, sician: The law requires t certificate has been signe irector, page 2 should be or	be Completed	25. Was case referred to medical examiner?	Hospital:	mre				-		(Check only or	sy med? 2 A No	prior to co death? 1 Yes	opsy findings available umpletion of cause of 2□ No
Division of Vita to Attending Physician: after death. Director: After this certification by the funeral director, I in by the funeral director.	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	28a. Date of Ir (Month, L	Day Year)	28b. Time of Injury	28 M	lc. Injury Work 1   Y	at	lo 28	3d. Describe h	ow inju	6 □Other (Specially occurred	
Div Hospital or 24 hours after Funeral Dir stely filled in I	edical Certi	4   Homicide	building,  Physician: To the be,  xaminer: On the basis and manner	etc. (Specify) st of my knows of examination stated.		occurred a	t the time	a, date and nion, deati		City or Tow	m, State	9)	
To the within 2 To the complet	Me	29b. Signature and title of certifier  30, Name and address of person w	fML ho completed cause o	Some f death (Item 2	(157) 23a) (Type, F		License D O	2000	776	,		ite signed (Month,	Day, Year)
St Regist	ate rar	30. Name and address of person w  Poris V. Pablo - 1  31. Date filed (Month, Day, Year)  APR 2 7 2	Bustos III	Strar's Signatu	num .	Street	NE	. Wa	54.1	C 5411	te	213 200	17

			1 - State Registrar	Department of Health and No Certificate of Death		iene 2004 15480
П	Physici	an	Decedent's Name (First, Middle, Last)     JOHN STAMBAUGH		2. Date of Death Month	Day Year
>	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	MAY	5 2004 4:05 P M
	Examin	er	FREDERICK MEMORIAL HOSPITAL		ı	4c. County of Death
2/20	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt		8. Date of Birth (Month, Day,	FREDERICK  9. Birthplace (State or Foreign
	Director		2.0 11 0500	rs. Months Days Hours Min.	May 5,	1911 Maryland
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location		10d. Inside City Limits
	Mary I-f sh	tor	Maryland Carroll County Keym	ar		1 ☐ Yes 2 No
	or 28a	irec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	within 72 hours after death with the Maryland ene. then 'natural', or items 23a or 28a-i show he Medical Examana Le notified at	Completed by Funeral Director	7311 Keysville Road	21757	Ur	nited States
	er dez	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. if Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Dican, etc.)	14. Race - American Indian, Black, White, etc.
36	irs aft	<b>by</b> F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give  3 🛣 Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
21215-0036	2 hou	ted	15. Decedent's Education 16a.	Decedent's Usual Occupation	1	6b. Kind of Business/Industry
2	thin 7	nple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	king	
	filed w Hygier other th	Con	0	cocer		grocery store
anc	intal F	Be c	J. Curtis Stambaugh		e (First, Middle, M et Forney	
Maryland	should and Men marke	P_		Mailing Address (Street and Number or Rur		
	and 2 salth a n 27 ls		Larry W. Stambaugh / son 713		Keymar, M	
altimore,	es 1 a of Hei fitem r othe		20a. Method of Disposition  20b. Place of cemeter,  1 XBurial 2 Cremation 3 Removal from State	Disposition (Name of crematory or other place)  May	10	Oc. Location - City or Town, State
<u>E</u>	Pages ment of lent: If it		'4 □Donation 5 □Other (Specify) Keysvi	lle Union Cem. 129	004	Keymar, Maryland
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show emy injury or other treumatic event, the Medical Examinating the notified at ORCE.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Sk		
	40200		23a. Part1. Enter the disease, or complications that caused the death. Do n	136 East Baltimore		Taneytown, MD 21787
	Physician		Immediate Cause (Final	Land He AND Free	or respiratory arres	st, Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (ex as a consequence of the control of the cont	Discourse of the same of the s	ucu	days
	Examiner		Sequentially list conditions b.	rejocarded for	factor	a dens
di-	De iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	To Cal	0	1:
	xecute and Il-tran	Examiner	that initiated events resulting in death) Last  C.  Due to (or as a consequence of the co	recope curant	viscula	u sis year,
760	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit			,		
289	g phy: as the	Physician/Medical	0.			
Вох	eath certifica attending ph for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of delivery
O.	e dea the att	sicia	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month Day Year
<u>Р</u>	res that the de signed by the a be detached f		9 ☐ Unknown  Part II. Dther significant conditions contributing to death but not resulting in	the underlying enuse given in Rest I	220 Did tobo	and the contribute to the course of death?
Vital Records,	signe d be	d by	COPD	ne underlying cause given in Pair i.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
S	w require been signal	Completed			24a. Was an	
Re	The lav	ошо			autopsy performe	
		BeC	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 ☐ n (Check only one)	ZNo 1 ☐ Yes 2 ☐ No
01 \	5	To		Other		ce 6 ☐Other (Specify)
	ding Ph h. After th funeral	on:	- Elitataran o Elitaring	ury Work?	28d. Describe how	injury occurred
Division	tent leatl lor: the	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	M 1 Yes 2 No	296 Leasting (Stre	
<u>&gt;</u>	after after Direction	ertii	4 Homicide determined 256. Flace of Injury - At nome, fair building, etc. (Specify)	i, street, factory, office	City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	alc	29a. Certifier 12 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place,	and due to the cau	se(s) and manner as stated.
k.	the H nin 24 the Fi	ledical	one) and manner stated.	or investigation, in my opinion, death occurr	ed at the time, date	e and place, and due to the cause(s)
	To To con	Σ	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month, Day, Year)
	0.1	-	NW(T)	1/26516	/	MAY 6 2004
	10		30 Name and address of person who completed cause of death (Item 23a) (T	1475 TANEY AV	E FR	ED MD 21702
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 32. Registrâr's Signature	10(1)		

### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng? 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth . 2004 April 29, Jean Prescott Schiffman 2:25 p.m 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31, 19 9. Birthplace (State or Foreign Country) Washington, D.C. 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Deys Hours 1 □ M 2 🖸 F 92 215-16-0477A Yrs. 1912 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland College Park 11 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4912 Muskogee Street 20740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Telephone Operator Telephone Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James P. McKallor Emma E. Alsop 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy A. Foster - Daughter 11609 34th Place, Beltsville, MD 20705 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 4/30/04 4 ☐ Donetion 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 Lanking 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final diseese or condition resulting in deeth) ere trovis alley PUV Due to (or as e consequence of): Due to (or es a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 🗆 Yes 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

ettending physician and I for usa as the burial-transit

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Completed

Be

Certification: To

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29a. Certifier

(Check only one)

31. Dete filed Month, Day,

been signed by

ata has been signe paga 2 should be

certificata : After this certifica e funeral director, r

ours eftar deeth.

To the Hospital of within 24 hours e To the Funeral Complataly filled

or Attending Physician:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Be Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death v Depertmant of Health and Mantel Hygiene. Important: If item 27 is merked other than \*natural\*, or itema 23s any injury or other traumatic event, the Medical Examines measure.

Baltimore, Maryland 21215-0036

with the Maryland

Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events and the cause of t resulting in deeth) Lest

25. Was case referred to medical examiner? 1 | Yes 2 | 1 | Yes 27. Menner of Deeth 5 Pending

1 Neturel 2 Accident investigetion 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

70

32. Registrer's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steled.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature end titl 29c. License number 29d. Date, signed (Month, Day, Year)

MI erson who completed cause of death/(Item 23e) (Type, Print) 30. Neme and eddress of

Annifoly Road #106 oclenton MD2113

State

Registrar **DHMH 16 Rev 6/95** 

MAN	47 	For State Registrar	• •	aryland / Dep	ndelible Ink partment of F ertificate of	lealth and Me	ental Hygie	•	15482
Physici /Medi		Decedent's Name (First, Middle, L Lynda C.	•				2. Date of Death Month April 2	Pay 2004 <sup>ear</sup>	3. Time of Death 1530 P M
Examir		4a. Facility Name (If not institution, g Prince George's	Hospital C	Center	Cheve		2 Day of Bigh		George's
Funeral Director		5. Social Security Number 218-74-4724  Usual Residence of Decedent	Sex 7. Ag 1 ☐ M 2 [ ☐ F	ge (In yrs. last birthday 49 yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, Y October 27	ear) 9. Birt. Co 7,1954 Wash	hplace (State or Foreign untry) ington, D.C.
death with the Maryland ms 23a or 28e-f show froust be notified at	ctor	10a. State 10b. County Maryland Prince (	George's	10c. City, Town or I	ocation Upper Mari	lbaro			10d. Inside City Limits 1X Yes 2 ☐ No
th with the	ai Director	10e. Street and Number 3616 Village Dr.	ive North		10f. Zip Code	20772	10g	. Citizen of What Co U.S.A.	untry?
ours after deal rai', or itams	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1XXYes 2 If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	tispanic Origin? (Spec an, Mexican, Puerto P Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:Blac	e, etc.
within 72 hours after ene. then "natural", or Ita tre Medical Exteruire	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or	(Giv 5+)	edent's Usual Occup le kind of work done DO NOT use retire Medical Disc	during most of workin d)	g	b. Kind of Business	
be filled within tal Hygiene. d other then	Be	17. Father's Name (First, Middle, Las	St)		Medical Disc	18. Mother's Name	(First, Middle, Ma.	iden Sumame)	ettet)
s 1 and 2 should be t f Health and Mental I ftem 27 is marked o other treumatic eve	2	Thomas (19a. Informant's Name/Relationship Minnie J. Johnson (1				Mi and Number or Rural In Drive N.E.		ity or Town, State, Z	
d permit. Pages Mary Mary Mary Mary Mary Mary Mary Mary	lner .	23a. Party Enter the disease, or confock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause	ensee	<b>2</b> 4	339 HINT PLA	ACE, N.E. WAS	HINGION, I	o.c. 20019	Maryland C.  Approximate Interval Between Onset and Death
The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burtal-transit	by Physician/Medicai Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) No 9 \( \text{MUnknown} \)	d.	2 Fetal death 3	□Ectopic pregnanc;			23d. Date of deli Month	very Day Year
iw requires that the de s been signed by the a should be detached	ompieted by Phy	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause giv	ren in Part I.	1 ☐ Yes 24a. Was an	24b. Were au	obably 4 Unknown
	e C	25. Was case referred to medical				26. Place of Death	autopsy performed 1 Yes 2 (Check only one)	d? death?	ompletion of cause of 2□ No
tending Phy Jeath. tor: After this the funeral d	Certification; To B	examiner?  1 XYes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine	be 28e. Place of In	28b. Time Injury (1:39)  1:39  1:39  1:39  1:39	of 28c. Injur Wor 1	y at 21 Nursing Hom y at 21 k? Yes 2 No 21	e 5 Residence Bd. Describe how  Von 6 for  Bl. Location (Stree  City or Town, S	a cxed c	rehicle which hiert. ral Route Number, L 4 South of
To the Mospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	Medicai (	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examination and/or	ath occurred at the tin nvestigation, in my o	ne, date and place, ar	nd due to the caus	e(s) and manner as	stated.
To the within 2 To the complet	Me	29b. Signature and title of certifier	. M.D		29c. Licens OCMI	_		Date signed (Month	
\ /		LING LI		(on zoa) (Type		Street,	Raltimor	e Marvlar	od 21201

		1 = For State Registrar	State of Maryland / Depa		lental Hygie	_	1548
Physici		1. Decedent's Name (First, Middle, Last) Hazel C. Smith			2. Date of Death Month April	Day 2004	3. Time of Death 6:50 P M
/Medio Examir		4a. Facility Name (If not institution, give s Millennium at	South River	4b. City, Town, or Location of Death Edgewate:		4c. County of Death	Arundel
Funeral Director		Usual Residence of Decedent	M 2 TF 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y Oct. 24,	Year) 9. Birth Cou 1926 Ma	place (State or Foreigr ntry) ryland
he Marylar 28a-f show outlied at	ector	Maryland Prince (	George 's	Lanham	T		10d. Inside City Limits 1 ☐Yes 2 ☐ No
th with t 23e or 2 ust be n	al Dir	10e. Street and Number 4920 Whitfield	d Chapel Road	10f. Zip Code 20706	100	Dnited S	•
ges 1 and 2 should be tiled within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1 □Yes 2√□No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ocify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: B1	can Indian, etc. .ack
od within 72 hours aff giene. er then "natural", or the Medical Exami	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	cation (Give (Give life.	dent's Usual Occupation kind of work done during most of workil DO NOT use retired) Housewife	ng 16	b. Kind of Business/Ir Priv	
d 2 should be filed the and Mental Hygin R7 Is marked other traumatic event.	To Be C	17. Father's Name (First, Middle, Last)  Ignatius Jones		18. Mother's Name	(First, Middle, Ma Lillian	iden Sumame)	
1 and 2 sho Health and Iem 27 Is my		19a. Informant's Name/Relationship (Type Richard S. Smith, 20a. Method of Disposition	Sr Son 62	ng Address (Street and Number or Rura  07 Willow Way, Cli sition (Name of natory or other place)	nton, MD		
permit. Pages 1 and Department of Health Important: If item 27 any injury or other trong.		1 🔀 Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)  21. Sign ture of Funeral Service License	Resurrect	ion Cemetery 4/28	/2004 ewart Fu	Clinton, neral Home	
Fnysician /Medical		23a. Part Enter the disease, or complications or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not enter e cause on a prince.  Due to (or as a consequence of):				Approximate Interval Between Onset and Death
te be executed Strain and Strain	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unioritying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):				
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
w requires that been signed b	by	Part II. Other significant conditions cont	tributing to death but not resulting in the u	À		co use contribute to the	1/
	Completed	General	Debility		24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of 2 \( \square\) No
ding Phy I. After this funeral d	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2	ospital: 1   Inpatient 2   ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury			e 6 ⊡Other (Specifinjury oœurred	y)
or A atter	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, strabuilding, etc. (Specify)		City or Town, S	,	
the Hospital in 24 hours a the Funeral I	Medical	one) 2 medical examin	ician: To the best of my knowledge, death er: On the basis of examination and/or inv and manner stated.	restigation, in my opinion, death occurre	d at the time, date	and place, and due to	the cause(s)
To the within 2 To the complete	2	29b. Signature and title of certifier		29c. License number  D57025	29d.	Date signed (Month,	Day, Year)
(3)		30. Name and address of person who con  AD 1 1 A CHOPR  31. Date filed (Month, Day, Year)	npleted cause of death (Item 23a) (Type,	gely Ave. Str. Z	31 Ann	apolis, r	MD.2140
Sta Registr		APR 2 9 2004	Bear & Son	(h)			

		1 - For State 4-29-04 Registrar Amend #26.Per	State of Maryla Phys. PC cr	nd / Depa	artmen rtificate	t of H	ealth ar Death	nd Mental F	lygien Reg. N	e20(	) 4	1548
Physicia /Medic	al	1. Decedent's Name (First, Middle, Las.  Juanita Genev	) ieve Southern	l	T			2. Date of Month Apri	1 15	20		3. Time of Death 5:38 P
Examin Funeral	ier	4a. Fecility Name (If not institution, give  Washington Adv  5. Social Security Number  6. Se	entist Hospit	s. last birthday)	4b. City,  If Under  Months	Tal	coma P  If Under 24  Hours	ark Hrs. 8. Date of (Month,	Birth Dey, Year	) 5	tgom	ace (State or Foreigny)
Director  works and show	ctor	578-26-3238  Usuel Residence of Decedent  10a. State 10b. County  DC	9	ity, Town or Lo	ocation		Vashin	Dec.	B <b>,</b> 19	08		d. Inside City Limit
72 hours a	leted by Funeral Director	10e. Street and Number  1200 Delaware  11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad	12. Was Decedent Ever in Armed Forces?  1	16a. Dece	1 ☐ Yes 2 dent's Usua kind of wor	Code  2  Jent of His  fly Cubar  No  I Occupa	20024 spanic Origin , Mexican, F Specify: tion uring most o	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race -	America White, e	States n Indian, tc.
of 2 should be filed within the and Mental Hygiene. Z7 is marked other than "traumatic event, the Mental Hygiene.	To Be Completed	Elementary/Secondary (0-12) 12th  17. Father's Name (First, Middle, Last)  Robert H. Si	College (1-4or 5+)	me. I	Sa	les_	Assoc	Name (First, Midd		Priva Sumame)		
of Health and 2 sho of Health and I item 27 is ma		19a. Informant's Name/Relationship (7) Myra B. Kennedy 20a. Method of Disposition	7 - Daughter		0 Apa	che	St., A	or Rural Route Nur. Adelphi,	MD 2	or Town, St. 20783 ocation - Ci		
permit. Pages Department of the Important: if its any injury or of once.		1 Deurial 2 Cremation 3 of 4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licens	Ar	lington	Nati Name and	onal	5 of Facility	/3/2004 Stewart Rd., N.E			lome	
ite be iysicia se bu	dical Examiner	23a. Part . Enter the disease, or compishork, or heart failure. List only of immediate drause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	nonia quence of): rova c quence oī).	· · · · · · · · · · · · · · · · · · ·			*	arrest,			Approximate nterval Between Onset and Death
that the death certifical led by the attending phy detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	el death 3	Ectopic pre Other (spe					23d. Date o Month		ay Year
w requires that been signed b should be deta		Part II. Other significant conditions cor	ntributing to death but not re	sulting in the un	iderlying ca	use giver	n in Part I.	T .		_		cause of death?
ysician: The law Is certificate has b director, page 2 s	e Completed	25. Was case referred to medical					OS Blace of	1 ☐ Yes	opsy formed? 2 <b>X</b> No	prio dea	r to comp	y findings availab iletion of cause of
Attending Pher death.	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	lospital: 1 ☐ Inpatient 2 €  28a. Date of Injury (Month, Day Yeer)  28e. Place of Injury - At he building, etc. (Speci	ZER/Outpatient 28b. Time of Injury	M 28	c. Injury a Work?	+ <b>⊠Nur</b> sır	Death (Check onlying Home 5 Re 28d. Describe 28f. Location	sidence e how inju	ry occurred		Route Number.
Hospi 4 hou Funei ely fill	edical	29a. Certifier 1 Acertifying Phys	sician: To the best of my known of the basis of examinating and manner stated.	owledge death	occurred a estigation,	t the time	, date and p	lace, and due to th	2 021102/01	l and manne	er as state due to th	ed. e cause(s)
To the I	Me	30. Name and address of person who co			Print)		936		Apr	te signed (M		
Stat Registra		Elwin Bu 31. Date filed (Month, Day, Year)  APR 2 9 2004	stos, M.D. 1	ature 🚄		St.,	N.E.	Wash., I	OC 2	0017		

State of Maryland / Department of Health and Mental Hygiene  $\bigcap_{i=1}^{n} \bigcup_{i=1}^{n} \bigcup_{j=1}^{n} \bigcup_{i=1}^{n} \bigcup_{j=1}^{n} \bigcup_{j$ For State Registrar Amend#'s 12.13.Per FH PGC 4-27-04cr Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last)
Mary E. Stewart April 24,2004 7:15am<sub>M</sub> **Physician** /Medical Fecility Name (If not institution, give street and number)
Washington Adventist Hospital 4b. City, Town, or Location of Death Tokoma Park 4c. County of Deeth Montgomery Examiner 7. Age (In yrs. last birthday) 88 yrs 8. Date of Birth (Month, Day, Year) NOV . 28, 1915 If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign La Plata, Md. 5. Social Security Number 578-64-7540 **Funeral** Months Days 1 □ M 2 💢 F Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours atter death with the Maryland ment of Heatth and Mental Hygiene. The state of Heatth and Mental Hygiene and it if item 27 is marked other than "netural", or items 23a or 28a-f show that yor other traumatic event, the Medical Exprinent must be notilited at my or other traumatic event, the Medical Exprinent must be notilited at 10c. City, Town or Location Adelphi P.G. 10d. Inside City Limits 10a. State Md. 1 Yes 2 □ No Director 10g. Citizen of What Country?
U.S. A. 10f. Zip Code 20783 10e. Street and Number 8308 Curry Place by Funera Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Black 35 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier/ Sales 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Retail Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Idell Thomas Benjamin Milburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8308 Curry Place Adelphi, Md. 20783 Brenda E. Trueheart 20c. Location - City or Town, State Suitland, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) April 30 2004 20a. Method of Disposition permit. Peges
Depertment of H
Important: If ite
sny injury or of
once. 1 Bunal 2 Cremation 3 Removat from State
4 Donation 5 Other (Specify) Lincoln Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robinson Funeral Home 1 Wash., D.C. 20001 1313 6th st. N.W. 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) P my **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use i 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 1 Yes 1 Yes No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Z No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

	_		1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of <i>rtificate of</i>	Health and Death	Mental H	ygiene 20 (	04 15486
	Physici		Decedent's Name (First, Middle, Last, CECELIA		ОТТ			2. Date of D Month APTIL		ar 3. Time of Death 5:10am M
	/Medi Examir Funeral		4a. Fecility Name (If not institution, give  HOLY CROSS HOSPI  5. Social Security Number  6. Se  579-07-4881	TAL 7. Age	a (In yrs. last birthday) 85 Yrs.	SILVER	If Under 24 H	ath	4c. County of D  MONTGON irth 9.	
	Director wow	J.C	Usuel Residence of Decedent  10a. State  10b. County	- <b>X</b>	10c. City, Town or Lo			June 1	15, 1918 F	10d. Inside City Limits
	th with the M 23a or 28a-f	al Director	D.C.  10e. Street and Number  700 7th St., S.W.	#321	Washingt	on 10f. Zip Code 200	24		10g. Citizen of What	XXYes 2 □ No Country?
900	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show than "must be notified at	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 [XDivorced	12, Was Decedent E Armed Forces? 1 ☐ Yes 24 N If Yes, Give Year or Dates:	0	Was Decedent of If Yes, specify Cut		Specify Yes or N irto Rican, etc.)	o- 14. Race - A Black, W Specify:	merican Indian, /hite, etc. Black
Maryland 21215-0036	ed within 72 h giene. er than "natu the Mudical.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire ministra	during most of w	orking	16b. Kind of Busine	ss/Industry
ryland	should be fitted and the standard Hygic started other numbtic event,	To Be (	17. Father's Name (First, Middle, Last) Preston Penny  19a. Informant's Name/Relationship (Ty	9.74			Donza	Penny	a, Maiden Sumame)	
	d 2 th a		Evelyn S. Boyd/Dau  20a. Method of Disposition  1 🕅 Burial 2 □ Cremation 3 □ F	ghter	11911 20b. Place of Dispondentery, cres	St Fran sition (Name of matory or other pla	cis Way,	Mithcel	oer, City or Town, State  1ville Md.  20c. Location - City	20721 or Town, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.	3	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	Be Was	22	Mem. Cer Name and Address 16 Kenne	ess of Facility J	ohnson &	Suitland, Jenkins I h. D.C. 20	nc.
3	Physician /Medical Examiner		23a. Part , Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	· 1						Approximate Interval Between Onset and Death DAYS
8760,		dical Examiner	Sequentially list conditions, lary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		COLITIS consequence of):					DAYS
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date of o	delivery Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con DEHYDRATIO		t not resulting in the ur	nderlying cause giv	ren in Part I.			to the cause of death?  Probably 4x Unknown
tal Reco		e Completed	25. Was case referred to medical						psy prior to priped? death' 2 No 1 Ye	autopsy findings available o completion of cause of ? s 2 \square No
Division of Vital Records,	ding Phys n. Alter this funeral din	ToB	examiner?	ospital: XXInpatien 28a. Date of Injury (Month, Day	28b. Time of	28c. Injui Wor	er: 4 🗆 Nursing		one) dence 6 □Other (Sp how injury occurred	Decify)
Divis	Hospital or Atten 14 hours after deatl Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined	building, etc.				City or To		
	To the Hosi within 24 ho To the Fund completely f	Medical	one)	ician: To the best of ier: On the basis of a and manner state	Manimation and or inv	estigation, in my c	pinion, death occ	e, and due to the urred at the time,	cause(s) and manner added and place, and de	ue to the cause(s)
	F 1 0 0		29b. Signature and title of certifier	Me		29c. Licens D3233			29d. Date signed (Mol	nth, Day, Year)
	(10)		30. Name and address of person who co Suresh K Gupta. 1		ath (Item 23a) (Type, I L Georgia		Silver S	SPRING M	d. 20902	
<b>A</b>	Sta Registra		31. Date filed (Month, Day, Year)  APR 2 7 2004	32. Registrar	's Signature	K)				

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ORIGINAL

			1 - For State Registrar	State	of Maryland		artmen rtificat			and M			004	15487
	Physici		Decedent's Name (First, Middle     Maria		ewart						2. Date of Dea Month 04	Day	Year 2004	3. Time of Death 7:15 A M
	/Medio Examir		4a. Facility Name (If not institution MAriner Nursin	, give street and nu					Location o		04	4c. Coun	ty of Death 1tgome	
	Funeral Director		5. Social Security Number 251-10-0057 Usual Residence of Decedent	6. Sex 1 ☐ M 28乙 F	7. Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Sept 22	, Year) 2, 1902	9. Birthe Coul Sou	place (State or Foreign ntry) th Carolina
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinatings be notified at once.	To Be Completed by Funeral Director	10a. State  MD  Mont;  10e. Street and Number  901 Arcola Av.  11. Marital Status  1 Never Married 2 Married  15. Deceden (Specify only higher  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Frank Johnson  19a. Informant's Name/Relations  Willie Akorli  20a. Method of Disposition  1 Surial 2 Cremation  4 Donation 5 Other (S.  21. Signature of Fureral Service	12. Was Dec Armed F   1   1   1   1   1   1   1   1   1	redent Ever in U.S. proes? 2 No ive Dates:  1-4or 5+) S •  20b. Place come	6a. Decede (Give life.) School 19b. Mailir 4141 Capispo eldery, creating (22	was Dececed Yes, special Yes, s	2090-dent of History Cubar of History Cubar of History Carlons of History Carlons of History Carlons of Herne of Mem	spanic Origin, Mexican Specify: tion uring most  18. Mother Ave. Ave.  Pk s of Facility	r's Name ie M r or Rura #10 d. 2	ecify Yes or No- Rican, etc.)	Special Specia	What Court  A  Ice - Americ  ack, White,  Business/In  ublic  me)  - City or To  Ster,	can Indian, etc.  ack dustry  Schools  Code)  own, State  PA.
68760,	law requires that the death certificate be executed  as been signed by the attending physician and as been signed by the attendance and as been signed by the attendance and as been signed by the attendance and as been signed by the attendance and as been signed by the attendance and as been signed by the attendance and as been signed by the attendance and as been signed by the attendance and as been signed by the attendance and as been signed by the attendance and as been signed by the attendance and as being a signed by the attendance and as being a signed by the attendance and as being a signed by the attendance and as being a signed by the attendance and as being a signed by the attendance and as being a signed by the attendance and as being a signed by the attendance and as being a signed by the attendance and as being a signed by the attendance and as being a signed by the atten	ledical Examiner	23a. PAA1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Meta: Due to b. Due to	caused the death. It each line.  Static Co (or as a consequent) (or as a consequent)	1on (ce of):			, such as c	cardiac	or respiratory and	est.	:	Approximate interval Between Onset and Death 2 Months
O. Box	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live	tcome of pregnancy pirth 2  Fetal de nant at time of death own	ath 3	Ectopic pro Other (spe						ate of delive	ory Day Year
ords, P.	w requires that been signed should be det	by	Part II. Other significant condition	ns contributing to c	eath but not resultin	ig in the ur	nderlying ca	ause give	n in Part I.					ne cause of death? ably 4 Unknown
Division of Vital Records,	The ate h page	Completed	OF Wassers of conditions									ried? 2⊠No	prior to cor death?	psy findings available inpletion of cause of
Ē	Physician; r this certifica ral director, I	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2□ER/	Outpatien	t 3 DO	A Other			i <i>(Check only or</i> me 5□Reside		ner (Snecifi	()
on of	iding Phys th. : After this funeral di	tlon: T	27. Manner of Death  1 🖾 Natural 5 🗆 Pendin 2 🗆 Accident investig	28a. Date (Mon		b. Time of Injury		Bc. Injury Work			28d. Describe ho			,,
Divisi	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Certification:	3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Place	of Injury - At home ing, etc. (Specify)	, farm, stre	eet, factory			-	28f. Location (SI City or Town		ber or Rura	l Route Number,
	he Hospital in 24 hours a he Funeral I pletely filled	edical	29a. Certifier 1X Certifyin (Check only one)	Examiner: On the b	a best of my knowled asis of examination ner stated.	dge, death and/or inv	occurred a restigation,	at the time in my opi	e, date and nion, death	l place, a	and due to the c ed at the time, d	ause(s) and mate and place,	anner as st and due to	ated. the cause(s)
,	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Doch	el-		ļ	License			2	9d. Date signe		Day, Year)
_	(3)		30. Name and address of person	who completed cau	se of death (Item 23	a) (Type, I	0.1	4257 Len		P. S	Filver S		/2004 Md.	
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 2 7 20	04	Registrar's Signature	from	r)	, myce				J		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 () () 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:30P M APRIL 22, 2004 SAWYER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CLINTON PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yeer)
APRIL 26,1938 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ м 💥 Б Months Days Hours Min. Yrs. FLORIDA 65 Director 256 58 3810 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "neturel", or items 23a or 28a-1 show other treumstic event, the Mcdical Examinal must be reutified at 1x√√Yes 2 □ No Directo PRINCE GEORGES CLINTON MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20735 9106 PINEVIEW LANE Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ②XNo Specify: Specify: BLACK þ 3 ☐ Widowed XX Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOMEMAKER 12TH Department of Heath and Mental Hyg. Important: If item 27 Is marked other any injury or other transcript. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be be la MONROE BUTLER NELLIE ADDISON ၉ 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 7811 JAYWICK AVE. FORT WASHINGTON, MD 20744 CAROLYN STANFIELD / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) COCONUT GROVE CEM. 01-MAY-2004 COCONUT GROVE, FL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or complication resulting in death)

a. Due to (25 a a a season)

Due to (25 a a a season)

Due to (25 a a a a season)

Due to (25 a a a a season) land SUITLAND, MD 20746 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executed) Due to (or as a consequence of): Examine burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s performed 2 🗆 No 2 No 1 Yes 1 ☐ Yes Physicien: After this certific funeral director, 26. Place of Death (Check only one, Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46374 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (328 Southern Ave JE WAPNING) gon . 2. Registrar's Signature 31. Date filed (Month, 7°2004 State Registrar

DHMH 17 Rev 1/2001

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Maryland

Baltimore,

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State of Maryland / Department of Health and Mental Hygiene

			AMEND TIEM #23a PER PE	18 G831 5/13/04 J		ificate of		-	Reg. No. 2	104	154	90
	Physic	ian	1. Decedent's Name (First, Middle, Last, Alta Veni	)				2. Date of De Month Marc	eth		3. Time of De 12:20	
	/Medi	cal	4a Fecility Name (If not institution, give	street end number)			4b. City, Town, or L	ocation of Death	4c. County			
			Williamsport N			If Under 1 Year	Willia	_		hing		
	Funeral Director		5. Social Security Number 6. Sec. 215-14-2516	7. Age (In yrs. 87	Yrs.	Months Deys		Feb. 1	y Year) 5,1917	9. Birthpi Coun MD	lace (Stete or F try)	-orei <b>gn</b>
	ylend wor		10a. Stete 10b. County		y, Town or Loca				···	1	0d. Inside City I	Limits
	e Men	ctor	MD Washin	gton Ha	gersto	own,					1 ☐ Yes 2	! <b>∑</b> No
	23e or 20	rai Dire	10e. Street end Number 16042 National	Pike		10f. Zip Code 217			10g. Citizen of V		iry?	
21215-0020	n 72 hours after death with the Merylend "natural", or Hems 23a or 28a-1 show edical Examinet ment be notified at	To Be Completed by Funeral Director	11. Merital Status  1 ☐ Never Merried 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		as Decedent of Yes, specify Cub ☐ Yes 2☐ <b>X</b> No	Hispanic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	ce - America ck, White, o White, o v:	etc.	
5-0		ietec	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	16e. Decede	int's Usuel Occu	pation during most of work ed)	king	16b. Kind of Bi		•	
212	iene.	ошо	Elementery/Secondary (0-12) 8th grade	College (1-4or 5+)		mstres			garmer	ic mi	- 9 •	
pu	al Hyg	Be C	17. Fether's Name (First, Middle, Last)	uogo.			18. Mother's Nam			10)		
Maryland	f Ment f Ment marked mattic a	2	George Thomas		401 14-95-		Gwend		Boppe	04.4. 7:-	0.41	
Ma	nd 2 st lith and 27 is n r traun		19a. Informant's Name/Relationship (Ty Jeanette Robise		196. Malling	52 Eng	tand Number or Rui lewood I	Rd. Hag	gerstov	vn, [	1D 217	40
Baltimore,	permit. Peges 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Importants: If item 27 is marked other than 'any injury or other traumatic avant, The Menone.		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	temoval from State Ce	lace of Disposi emetery, crema dar La	tion (Name of atory or other pla awn Men	morial P	,2004 ark	20c. Location -			
Balti	pemit. Depertrimporta any inju		21. Signiture Homeral Service Licens	*/	Do	Name and Addr onald E O.BOX	ess of Facility Edwin The 310 Cle	ompson ar Spr	Funera	al Ho D 21	ome, I 722	inc
		П	23a. Part1/Enter the disease, or complishock, or heart feilure. List only or	ications that caused the death ne cause on each line.	n. Do not enter	the mode of dy	ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	en
ilai, A	Physician /Medical		Immediate Cause (Final	Anda A	201-1-	A. A	CONAL ASPII	DATTT/INT		1		
	Examiner		disease or condition resulting in death)	Due to (o	r as a conseque		POWER WOLT	MILON		- 1	0 minut	res
	ed sit	niner		Projectile	Vound	hing				1	D minu	tes,
Ć.	tificate be executed ig physician and es the burial-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Smail Beu	r es a conseque		-101 1			7	omnu	
68760,	ate be nysicia he bur	edicai	Ceuse (Disease or injury that initiated events resulting in death) Last		as a conseque	ence of):	rious				26 rec	ν>
39 ×	entifice ding pt se es t	Med		1						1		
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P.O.	t the d by the tached	Physician/M	Sende dement	•	uiting in the und	ieriying cause gi	ven in Pen I.	230. Did t	obecco use co⊦ res 2ÆNo		ably 4 □ Un	
Ś	es the igned be de	by	JAME GENNEMET			B. H. 41-114		-				
ecorc	The law requires that the death certificate be executed at a has been signed by the attanding physician and paga 2 should be detached for use as the bunal-trensit	Completed	idrobetes mell	dus				24a. Was perfor	an autopsy rmed?	eva	re autopsy find ilable prior to npletion of caus leath?	_
<u>e</u>								1□ Y	es 2X No	10	Yes 2□ No	>
Vit	Physician: The this cartificata rel diractor, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1   Inpatient 2	ED/Outpations	2 DOA 0t	26. Place of Deal			(0/-		-
on of	ng Pi	tion: To	27. Menner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	TE INDISHING THE	ome 5 Resid	ow injury occurr		1	
Division of Vital Records,	or Attending Feitar death. Diractor: After	Certification:	2 Accident investigetion 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At ho building, etc. (Specify	ome, farm, stree			28f. Location (S City or Tow	Street and Numb n, State)	er or Rural	Route Number	<i>r</i> ,
>	Hospital	Medicai Co	29a. Certifier (Check only one) 1  Certifying Phys 2  Medicat Examir	ician: To the best of my knowner: On the basis of exeminat end manner steted.	wledge, death o ion end/or inve	occurred at the ti stigation, in my	me, date end place, opinion, death occur	end due to the or red at the time, or	cause(s) and ma date and place, a	nner as sta and due to	ited. the cause(s)	
	within 2 To the	Me	29b. Signeture end title of certifier			29c. Licens	se number	:	29d. Date signed	ל (Month, ב	lay, Yeer)	
	ND,		1900me			0337	00		March	14.7	2004	
	5		30. Neme end address of person who co		23e) (Type, Pr	Soous	aro rel					
	Sta	te	JED E. HOWE .  31. Dete filed (Month, Day, Year)	7547 Overloo		1200NATA	JAU 144					
	Registr		MAR 16 20	NA Assessor A	B. Sne	which a						

			1 - For State Registrar		te of Ma	aryland	/ Depa	artmen	t of H		and M	fental H	ygier Reg. N				5491
	Physici	an	Decedent's Name (First, Midd	le, Last)				,				2. Date of D		)av	Year	3. Time	of Death
-	/Medic		Harold	E.		S	200	5				April	27,	2004	· oui	7:45	A M
	Examin	er	4a. Facility Name (If not institution	-	nd number)			4b. City,	Town, or	Location of	of Death		4	lc. County o	f Death		
			607 Mary Stre	et				Fr	eder	ick				Free	deri	.ck	
	Funeral		5. Social Security Number	6. Sex 1 √2 M 2[		e (In yrs. las		If Under Months	1 Year Days	If Under Hours	Min	8. Date of B	irth Day, Yea	ır)	9. Birth	place (State	e or Foreign
	Director		218-30-2807	X M Z		71	Yrs.		Zujo			July 2	9, 1	932	Vire	ginia	
	pug *		Usual Residence of Decedent  10a. State 10b. Count	,		10c City	Town or Lo	cation								I Od. Inside	City I inside
	sho	'n				ioc. ony,											es 2 🗆 No
	Ne N 188-1	ecto		derick			Fr	ederi									2 2 110
	uter death with the Marylan r Items 23a or 28a-1 show	Funeral Director	10e. Street and Number					10f. Zip					10g. C	Citizen of Wh	nat Cour	itry?	
	s 23g	ra	607 Mary Str						2170					ted St			
	er de	nne	11. Marital Status	Λ σστ	s Decedent red Forces?			Vas Deced f Yes, spec	lent of Hi city Cuba	spanic Ori n, Mexican	gin? (Spi 1, Puerto	ecify Yes or N Rican, etc.)	lo-		<ul> <li>Americ</li> <li>White,</li> </ul>	can Indian, etc.	
36	s aft	by F	1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	ried 1	Yes 2 1 h es, Give er or Dates:	1954 1955	_	I □ Yes 2	2₩ No	Specify:				Specify:	Whi	Lte	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-1 show Jigal Evan i withinki be indified at	ad t		nt's Education	er or Dates.		16a. Deced	loota Haus	I Ossuss	tion			1.Ch	Kind of Dun	:	-dd	
15	n 72 i "na	Completed	(Specify only highe		leted)		(Give	kind of wor DO NOT us	rk done a	<i>luring</i> mosi	t of work	ing	160.	Kind of Bus	iness/in	Justry	
12	withi ene. thar	шć	Elementary/Secondary (0-12)	Col	lege (1-4or 5	+)				, Manag	202		R.	etail	Cro	0021	
	filed Hygi ther snt. 1	ŭ	17. Father's Name (First, Middle,	Last)				LIOU	uce			First, Middi				cery	
an	d be antal cad o	o Be	Ralph Snoots									enner	-,	, , , , , , , , , , , , , , , , , , , ,			
$\geq$	hould Me mark mati	၀	19a. Informant's Name/Relation	shin /Tyne Prir	at)		10h Mailir	a Address	/Stroot a			al Route Num	bor City	. or Tour	toto Tie	Cadal	
Maryland	d 2 s th an 7 is trau		Kathy Doody/Dau		,												
	1 an Heal am 2 ther		20a. Method of Disposition	ignter			ce of Dispo			New		ket, Ma		and 21 Location - C		-	-
סַ	ages ant of it: If it		1   Burial 2 □ Cremation		from State	сеп	netery, cren	natory or or	ther place	9)					-		
ţi	t. Partmer		'4 □Donation 5 □ Other (			Tair	CIAWII	Memori	al Pa	rk A	pril	30,2004	Roc	kvill	e, M	lary1a	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", o any injury or other traumatic avant. If a Me Jigal Evail once.		21. Signature of Funeral Service	2 CHED	М	01386	R R	Namean ockvi ockvi	lle, 11e,	Inc. Mary	300 1 300 1 1 and	ert A. ) West 1 20850	Pum Moni 280-2	iphrey tgomer 05	Fur y A	eral venue	Home/
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications t only one caus	that caused	the death.	Do not ent	er the mode	e of dying	g, such as	cardiac c	or respiratory	arrest,			Approxim Interval B	ate
7.	Physician		Immediate Cause (Final disease or condition	-	live	V F	Failu	20								Onset and	d Death
7	/Medical		resulting in death)	a	live ue to (or as Col	a conseque	nce of):									, price	7 700
	Examiner				col	200	Car	cer								5 no	er.v.C
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0. 0	ue lo (cr as	Conseque	nce oi).									-	
	rate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c ===											-11		
o,	an ar rial-t	EX	resulting in death) Last	D	ue to (or as	a conseque	nce of):										
8760,	te be ysicia re bu	cal		d													
9	The law requires that the death centificate be executed tile has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ed	-=														
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		s, outcome								- 10	23d. Date	of delive	ry	
	deatle atte	Ca	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🗆	Live birth Pregnant at			Ectopic pre Other (spe						Month	1	Day	Year
P.0	that the de led by the a detached	hys	9 🗌 Unknown	91.1	Unknown												
	res tha igned be det	by P	Part II. Other significant condition	ons contributin	g to death bu	at not resulti	ing in the ur	iderlying ca	ause give	n in Part I.		23e. Did	tobacco	use contrib	ute to th	e cause of	death?
ğ	quire n sig uld b											1 🗆	Yes 2	2 <b>X</b> No 3	☐ Prob	ably 4	Unknown
Records,	w requir s been si should	Completed										24a. Wa	s an	24b We	re auto	psy finding:	s available
	he ta e has	mc										auto	opsy ormed?	pridea	or to cor ath?	npletion of	cause of
Vital		C	25. Was case referred to medica							00.01	45	1 Yes	2 N	0 1	] Yes	2 🗷 No	
Ē	Physician: The faw this certificate has t ral director, page 2 s	o B	examiner?	Hospital:	4 🗇 lmanetia	nt 2 EF	3/0	• • • • • • • • • • • • • • • • • • • •	Othe			(Check only					
ō	Phy this ral d	$\vdash$	27. Manner of Death	28a.			Bb. Time of		^	4 LI NUI		ne 5 X Res 28d. Describe				)	
on	ding Ph h. After thi funeral	ţ	1 Natural 5 Pendi	ng gation	Date of Injur (Month, Day	Year)	Injury	М	Bc. Injury Work	? ′es 2 □ N			11011 1111	ary 00001100			
Division	or Attanding after death. Diractor: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	not be	Place of Inju	rv - At home	e farm stre			05 2		28f. Location	Stroot a	and Number	or Dura	l Pouto Mu	m has
Ö	after Dira	erti	4 Homicide determ	inea 200.	building, etc	. (Specity)	o, raiii, stre	et, lactory,	Onice		2	City or To			oi nuia	HODIE IVU	mber,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 X Certifyi	ng Physician:	To the best of	f my knowle	ndan doath	annured o	et the time		d alega a	and division to the					
	Hos 24 ho Fun Fun stely	Medical	(Check only 2 Medical	Exeminer: On	the basis of manner sta	examination	n and/or inv	estigation,	in my op	e, date and inion, deat	n place, a th occurre	and due to the ed at the time	cause(s , date an	s) and mann nd place, and	er as st d due to	the cause	(s)
	thin the comple	Me	29b. Signature and title of certifie		THAIHH SIA			29c	License	number			29d D:	ate signed (	Month I	Day Voar	
	. 1		1 Km/n	~~		a	0	7	) (	118	64	,		ril 2			1
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				nd i or i	2 4	6 R 7	Riem	es J	5hu	ser?	Drive	e F	red	erick	· W	10 Z	1702
	Sta Registr		31. Date filed (Month, Day, Year, APR 3 0	2004	32. Registra	r's Signatur	B	Spa	the	/							

			For State Registrar	State of M	laryland		artment of H		Mental Hygi	iene g. No. 20 (	04 15	192
			Decedent's Name (First, Middle	e, Last)					2. Date of Deat	n	3. Time of	f Death
	Physici /Medic		Povorlov	Victoria	Sel	zer			April	-	oot 18:30	PM
	Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Deat	h	4c. County of	Death.	
			PENINSULA REGIO	Medica	COP	1111		ALISON	<b>,</b>		COMICO	
	Funeral Director		5. Social Security Number 261–62–9505	6. Sex 7. A	ge (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.		rear)	9. Birthplace (State of Country) /irginia	or Foreign
	pug *		Usual Residence of Decedent  10a, State 10b, County		10c. City,	Town or Lo	cation				10d. Inside C	ity Limits
	/ sho	ō									1 <b>X</b> Yes	2 □ No
	28a-	Funeral Director	Maryland Wicom  10e. Street and Number	1100	Sa	lisbu	10f. Zip Code		10	ng. Citizen of Wh	nat Country?	
	3a or	Ö	227 Canal Park	Drive Unit	#405		2180	04		USA	1	
	death ms 2	nere	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	. 13. \			Specify Yes or No- to Rican, etc.)	14. Race	- American Indian, White, etc.	
36	d within 72 hours after death with the Maryland jiene rithan "natural", or Items 23a or 28a-f show the Medical Exarcinate out be collilled at	by Fu	1 ☐ Never Married 2 X Marri 3 ☐ Widowed 4 ☐ Divorced	ried 1 □ Yes 2 <b>X</b> If Yes, Give	] No		1 □ Yes 2 No			Specify:	White	
21215-0036	hour tural	ed b		Year or Dates	· I	16a. Dece	dent's Usual Occur	pation		16b. Kind of Busi		
7.	n nat	Completed	(Specify only highe	st grade completed)  College (1-4or	. 5.)	(Give	kind of work done DO NOT use retire	during most of wo	rking		,	
212	d within giene. r than "	mo.	Elementary/Secondary (0-12)	College (1-40)	3+)	Ret	ail Sale	S		Retai	1	
b	be filed Ital Hygi od other event, t	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle, M	faiden Sumame,	)	
Maryland	2 should be and Mental Is marked aumatic ev	To	Karol J.	Gebo, S	r.			Margai	ret -	E	Bondurant	
Jar	2 sho and Is m		19a. Informant's Name/Relations	ship (Type, Print)					ural Route Number,			
	s 1 and 2 should I Health and Men item 27 Is marke other traumatic		William Selzer 20a. Method of Disposition	(husband)	20h Pla	227 C	anal Parl	c Drive,			Maryland	2180
Ď	m O		1 Burial 2 Cremation		e _ cer	metery, crer	natory or other pla		1 24,2004		bury, Mary	brefv
<b>Baltimore</b> ,			' 4 ☐ Donation 5 ☐ Other (S		Pars	22	Cemetery  Name and Addre	ess of Facility			_	
Ba	permit. Departr Importa any inju		> Kill R	Duney (	FSP	H- 5	olloway 1 Ol Snow 1	Tuneral H Hill Road	l, Salisbi	ıry, Mar	Associat	804
Г			23a, Part1. Enter the disease, or shock, or heart failure. List	r complications that cause tonly one cause on each	ed the death. line.	Do not ent	er the mode of dying	ng, such as cardia	c or respiratory arre	est,	Approximat Interval Bet Onset and	tween
	Physician		Immediate Cause (Final disease or condition	a. Ong	estir	e H	leart h	El lune			Orisot and	Dodin
	/Medical Examiner		resulting in death)	Due to (or	s a conseque	ence of):	0					
	72		Sequentially list conditions,	b. Poin	CA CQ1	nce of):	CVCLY	noma				
	Ited Insit	nln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<								
<u>,</u>	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	Due to (or a	s a conseque	ence of):				<u></u>		
8760	ate be executed physician and the burial-transit	dical		d								
9	tifica ng ph as th	(0)	IS SECULIS		-							
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			Ectopic pregnanc	у		23d. Date Mont		Year
O. E	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of dea	ath 5	Other (specify) _			, ividita	. Duy	
α.	that the od by detact		Part II. Dther significant conditi	ons contributing to death	but not result	ting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contrib	oute to the cause of o	death?
ecords,	uires n sign	d by							1 □ Ye	s 2 🗆 No 3	☐ Probably 4 ☑	Unknown
50	w require been si should I	lete							24a. Was ar		ere autopsy findings	available
$\mathbf{\alpha}$	The fav	Completed							autops perform 1 Yes 2	ned?/ de	or to completion of a ath? ∃Yes 2□ No	ause of
Vital		O	25. Was case referred to medica	ul l				26. Place of De	ath (Check only one		2103 20110	
<b>\</b>	Si di	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa	tient 2 🗷 🖹	R/Outpatier	it 3□ DOA Ott	ner: 4 🗆 Nursing l	Home 5 ☐ Reside	nce 6 Other	(Specify)	
n of			27. Manner of Death 1 ☑Natural 5 ☐ Pendii	28a. Date of In (Month, D	jury 2 Day Year)	28b. Time of Injury	28c. Inju	ry at	28d. Describe ho	w injury occurred	į	
Sio	uttsndii death. ctor: A y the fu	catio	2 Accident investi	igation not be				Yes 2 □No				
Division	if or Attsnd after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined   286. Place of I	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office		City or Town		or Rural Route Nurr	1Der,
ш	spital ours a seral filled		29a. Certifier 1 Certifyii	ng Physician: To the bes	st of my know	rledne, deat	occurred at the ti	me, date and place	e, and due to the ca	use(s) and man	ner as stated.	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical		Examiner: On the basis and manner:	of examination							5)
	To th withir To th comp	Me	29b. Signature and title of certifie	ər			29c. Licens	-	29	d. Date signed (	(Month, Day, Year)	
	. / ^			mo				154127		4/20	2104	
	2 m		30. Name and address of person	who completed cause of	death (Item		Street	5a1	isbury	mo	2/80	74
	Sta Regist		31. Date filed (Month, Day, Year, APR 2	6 2004 32. Regis	rar's Signatu		Spor	KN				
				7								

Beverly Selzer 201-63-9505

			For State Registrar	State of Maryland	d / Depa		lealth and N	1ental Hygie	_	15693
	Physici /Medio		Decedent's Name (First, Middle, Last,     Linda Susan	Sharp				2. Date of Death	Dav Year	3. Time of Death 12:12 PM
	Examir		4a. Facility Name (If not institution, give 4505 Public Landir			4b. City, Town, o	r Location of Death Hill		4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Set 175–60–9668  Usual Residence of Decedent	7. Age (In yrs. la M 2XF 40	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye January 16	9. Bird 7. 1964 Pe	thplace (State or Foreign buntry) ennsylvania
	Maryland I-f show fied at	tor	10a. State 10b. County  Maryland Worcest		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2💢 No
	3a or 28a	i Director	10e. Street and Number  4505 Public Landi		<i>JW</i> 1111.	10f. Zip Code 21863		1	Citizen of What Co	juntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rightry or other traumatic event. The Medical Examinar must be multiled at once.	by Funeral	· · · · · · · · · · · · · · · · · · ·	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ⊠No If Yes, Give Year or Dates:	1		ispanic Origin? (Spin, Mexican, Puerto		14. Race - Ame Black, White	
21215-0036	ithin 72 hc ie. ien "natur i Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. I	ient's Usual Occup kind of work done o DO NOT use retired	ation during most of work f)	ing 16b	. Kind of Business/	Industry
	be filed winter Hygien of other the	Be	12 17. Father's Name (First, Middle, Last)	2	Exec	cutive As	18. Mother's Name	(First, Middle, Maid		ty
Maryland	2 should and Men Is marke raumatic	P.	James Russell  19a. Informant's Name/Relationship (Type					al Route Number, Cit		
	tges 1 and nt of Health if item 27 or other t		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	IGINOVALITOTTI STATE	ace of Dispo metery, cren	sition (Name of natory or other plac	e)		Location - City or	Town, State
Baltimore,	permit. Pa Departmer Important any injury once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	ee CCCP			and the state of t	ril 22, 200 ome Profes		1, Maryland ssociation and 21804
	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	Do not ente	er the mode of dyin	HIII KOAO g, such as cardiac c	, Salisbui or respiratory arrest,	ry, Maryı	Approximate Interval Between Onset and Death
	Examiner	-i-		Due to (or as a consequence).  But UEL  Due to (or as a consequence)		TRUC	770 ~			3 ms
9200	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque		ARCIN	6 MA			54 mes
P.O. Box 68	Attending Physician: The law requires that the death certificar death.  death.  sctor: After this certificate has been signed by the attending ph  sctor: After this certificate has been signed by the attending ph  y the funeral director, page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1□Live birth 2□Fetal o 4□Pregnant at time of dea 9□Unknown	death 3□	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions con	ntributing to death but not result	ting in the un	derlying cause give	on in Part I.		10	the cause of death?
Vital Records,	The law re cate has bee page 2 sho	Completed						24a. Was an autopsy performed?	prior to co	copsy findings available ompletion of cause of
Vita	ysician: s certific director,	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ♠ No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3□ DOA Othe	26. Place of Death	Check only one) ne 5 Residence	6 Other (Sage	(A <sub>2</sub> )
Division of	nding Phyath. ath. r: After thi	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury Work	at 2	28d. Describe how in		(iy)
Divis	tal or Atters after des	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office	2	8f. Location (Street and City or Town, Sta	and Number or Run ate)	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	cician: To the best of my knowler: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurre	nd due to the cause od at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier  William P	· m= su	iù n	29c. License	number		Pate signed (Month,	* '
10	LMP		30. Name and address of person who con	LIN SOUR	RE '	Print)	Willia ALTIM	m P. McGu	ire 1) Zu	237
	Sta Registra		31. Date filed (Month, Day, Year) APR 2 2 2	32. Registrar's Signatu		Spar Spar	K	*		

Physici.		1. Decedent's Name (First, Middle,	Last)							2. Date of De	Reg. No ath Da		Voca	3. Time of Dea
/Medic		Harry James S	mith							April			Year	1430
Examin		4a. Facility Name (If not institution, g				4b. City,		Location of			40	. County		
	e.		al Medi		154	(6) (		1156				NI	com	
eral ector		214-28-2071	SSex Ma DM 2□F	7. Age (In yrs	s, last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da 8-27-1	y, Year,	)	9. Birthp Coun	face (State or Fo try) Md •
78		Usual Residence of Decedent  10a. State 10b. County	worcester	10c. C	ity, Town or Lo	cation							1	0d. Inside City Li
any injury or othar traumatic event, the Medical Exarcurer was be notified as once.	Director	Md. Wicomi	eo-		Snow Hi	11								X Yes 2 □
	Dire	10e. Street and Number				10f. Zip						tizen of W	hat Coun	try?
	erai	4008 Paw Paw Cr		edent Ever in I	118 13 1		863	enanio Ori	nin? (Sn	poity Voc of No	US		- Amoric	an Indian,
	Completed by Funeral	1 Never Married  Married 3 Widowed 4 Divorced	Armed For IX Yes If Yes, Gi	orces? 2    No ive   Kore	ean	If Yes, spec		Specify:		ecify Yes or No Rican, etc.)			, White,	
	ieted	15. Decedent's (Specify only highest			16a. Deced	dent's Usua kind of wo DO NOT us	rk done o	lurina mos	t of work	ring	16b. K	(ind of Bus	siness/Inc	lustry
	ошо	Elementary/Secondary (0-12)	College (	1-4or 5+)		nce 0					Aut	o Fi	nance	e Co.
	0	17. Father's Name (First, Middle, La	· ·						er's Nam	e (First, Middle	Maider	Sumame	)	
	To B	Harry Smith						Mary	Sc	otten Si	mith	L		
		19a. Informant's Name/Relationship				-				al Route Numb				
		Evelyn Smith, W	<u>life</u>	20h.	4008 Place of Dispo			Creel		. Snow		Md ocation - C		
		1 Burial 2X Cremation 3		State	cemetery, crer	natory or o	ther place	´ I					•	WII, State
mi	3	* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice		Gre	ematory	OI L				6-04	рет	mar,	De.	
once.		+ Crewill	7			Shor	t Fu		Ĺ Ho	me, INc	•			
٦		23a. Part1. Enter the disease, or co shock, or hear failure. List or	emplications that	caused the dea	ath. Do not ent						rrest,			Approximate Interval Betwee
the burial-transit the burial-tr	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. End of any ing Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a conse	quence of):									
	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 ☐ Fet nant at time of	af death 3	Ectopic pr						23d. Date Mont		ry Day Year
	占	Part II. Other significant condition	s contributing to d	leath but not re	sulting in the u	nderlying c	ause give	en in Part I.			obacco (		oute to th	e cause of death
										24a. Was autop	SV	de	ath?	osy findings avai apletion of cause 2 No
	Completed									perfo		11	183	
	Be Completed	25. Was case referred to medical examiner?	Hospital:		75000		Othe	26"		1 ☐ Yes	2 No			
	To Be Completed	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date (Mon	Inpatient 25 of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury		8c. Injury Work	er: 4 □ Nu	ırsing Ha	1 ☐ Yes	2 No ne) dence	6 Other	(Specify	)
	To Be Completed	examiner? 1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date (Mon	of Injury th, Day Year)	28b. Time of	M 2	8c. Injury Work	er: 4 □ Nu at	rsing Ho	l 1 ☐ Yes  h (Check only o	2 No	6 Other	(Specify	) Route Number,
	Certification; To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigal  2 Accident 6 Could no determine  29a. Certifier 1 Certifying	28a. Date (Month to be ed 28e. Place build	of Injury th, Day Year) of Injury - At I ing, etc. (Spec	28b. Time of Injury	M eet, factory	8c. Injury Work 1 1	er: 4 Nu	No place,	1 ☐ Yes  h (Check only come 5 ☐ Resident 28d. Describe I  28f. Location (City or Town	2 No one) dence now injure Street are wn, State	6 □Other ry occurre and Number a)	(Specify d or Rural	Route Number,
	To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigal 3 Suicide 6 Could no determine  29a. Certifier 1 Certifying (Check only 2 Medical Ex	28a. Date (Month to be ed 28e. Place build	of Injury th, Day Year)  of Injury - At I ing, etc. (Spec  best of my kn asis of examin	28b. Time of Injury	M eet, factory	8c. Injury Work 1 1	er: 4 Nu  at  cat  construction  des 2 1  des date an  pinion, dea	No place,	1 Yes h (Check only of me 5 Resid 28d. Describe I 28f. Location (: City or Tou and due to the red at the time,	2 No one) dence now injure Street arr wn, State cause(s)	6 □Other ry occurre and Number a)	(Specify d r or Rural ner as sta	Route Number, ated. the cause(s)
completely filled in by the funeral director, page 2 should be delached for use as t	edical Certification: To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could no determine  29a. Certifier (Check only one)  1 Certifying 2 Medical Expending 1	28a. Date (Mon to build saminer: On the band man	of Injury th, Day Year)  a of Injury - At the ing, etc. (Spector of examinating stated).  Make the ing of examinating stated.	28b. Time of Injury	M eet, factory	8c. Injury Work 1 1	er: 4 Nu  at  cat  construction  des 2 1  des date an  pinion, dea	No d place, th occurr	1 Yes h (Check only of me 5 Residence 28d. Describe I 28f. Location (3 City or Tov and due to the red at the time,	2 No ne) dence now infu Street arr vn, State cause(s) date and	6 Other ry occurred and Number and Number and place, are the signed	or Rural or as stad due to  (Month, L	Route Number, ated. the cause(s)

	For State Registrar			/ Departmo			Re	g. No. 20	
ysician	Decedent's Name (First, Middle,						2. Date of Death Month		3. Time of Death
Medical	MARK DANIEL SMI	TH					ADRIL	23 20	24 0651
er	4a. Facility Name (If not institution,		ber)	4b. C	ity, Town, or	Location of Dea		4c. County of	
- *	7,6	NA1 M	arent	CONTE		SALISE		All	MICU
	5. Social Security Number 214-66-8337	3. Sex 7 1 XM 2 ☐ F	'. Age (In yrs. Ias 48	Yrs. If Ur Mont	der 1 Year hs Days	If Under 24 Hr. Hours Min		Year)	Birthplace (State or Foreig Country) ALISBURY, MD.
	Usual Residence of Decedent		10-01-	-					
_	10a. State 10b. County			Town or Location					10d. Inside City Limit 1 X Yes 2 N
Director	MD WICO	MICO	SAL	LSBURY					
<u> </u>	10e. Street and Number			10f.	Zip Code		10	Og. Citizen of Wha	it Country?
	1253 MIDDLENECK					1804		USA	
;	11. Marital Status	Armed Ford	lent Ever in U.S. ces?	13. Was De	specify Cuba	ispanic Origin? ( in, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □Yes 2 If Yes, Give Year or Dat		1 □ Ye	s 21XNo	Specify:		Specify:	WHITE
•	15. Decedent's			16a Decedent's I	Isual Ossus	ation		16h Kind of Rusin	
í	(Specify only highest	grade completed)		16a. Decedent's U (Give kind of life, DO NO	work done of	ation during most of wi	orking	16b. Kind of Busin	ess/industry
Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)		UMBER	<b>'</b>		עון וכו	MBING
3	17. Father's Name (First, Middle, L	ast)		11	OFIDER		me (First, Middle, N		IDING
Be		-0.7			1			and of the state of	
0	JOHN E. SMITH  19a. Informant's Name/Relationsh	- (Time Print)		40h Mailine Add	(Столь	LOIS TA	AYLUK Rural Route Number,	City on Town Cto	to Zin Code)
	ADELINE SMITH -  20a. Method of Disposition	SPOUSE		ce of Disposition (		K DRIVE,	SALISBURY	MARYLAN 20c. Location - Cit	
	1 X Burial 2 ☐ Cremation	B □Removal from St	con	netery, crematory	or other plac	1		oc. Location - Cit	y or rown, state
	`4 □ Denation 5 □ Other (Sp.		PARS	SONS CEME					, MARYLAND
	21. Signature of Aneral Service L	censos	00	22. Name	and Addres	ss of Facility BO	OUNDS FUNE	RAL HOME	I, INC.
	23a. Part1. Enter the disease, or o shock, or heart failure. List o	SI	lly	705 E	EAST M	AIN STRE	EET, SALISE	BURY, MAR	YLAND 21804
dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or Due to (or c.	r as a conseque	nce of):					
Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		th 2 ☐ Fetal d nt at time of dea	eath 3 Ectopi	c pregnancy (specify)			23d. Date of Month	f delivery Day Year
/ Ph	Part II. Other significant condition	s contributing to dea	ith but not resulti	ing in the underlyin	ng cause give	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
Q D	LOID: BENA	L FAIL	URK	; OB1	ESITY		1 □ Ye	s 2 No 3	Probably 4 Unknow
ere	KLINE FELT						24a. Was an	24h War	e autopsy findings availab
	IN 110 FULL	1213	2110	9 01110			autopsy	ed? deat	e autopsy findings availat to completion of cause on h?
	05.14							No 1 🗆	Yes 2□ No
Be	25. Was case referred to medical examiner?	Hospital:			Oth		eath (Check only one		
0	1 ☐ Yes 2 No  27. Manner of Death	1 🖾 Ini		NOutpatient 3  8b. Time of	DOA 28c. Injury		Home 5 ☐ Resider		Specify)
tion	1 Natural 5 Pending 2 Accident investiga		, Day Year)	Injury	Work	Yes 2 □No	200. Describe no	w injury occurred	
Certification:	3 Suicide 6 Could not determine	200. Flace 0	of Injury - At hom g, etc. (Specify)	e, farm, street, fac	tory, office		28f. Location (Str. City or Town,	eet and Number of, State)	r Rural Route Number,
Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the b xaminer: On the bas and manne	sis of examinatio	edge, death occur n and/or investigat	red at the tim tion, in my op	ne, date and place pinion, death occ	e, and due to the cal urred at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
M	29b. Signature and title of certifier				29c. License	number -	29	d. Date signed (N	fonth, Day, Year)
	De tha	drub			121	09/2		4-27	-04
	30. Name and address of person w	/		(Ze) (True - Deien)	- /		SAUSKIN	, ,	

		4	For State Registrar	State of Ma	rylan		artmen rtificat			ind M		20	04	15496
			Decedent's Name (First, Middle, La	st)							2. Date of Death		V	3. Time of Death
	Physici /Medic		William Carl Sm	ith, Jr.							Month 4	Day 23	Year 2004	23:23M
2	Examin		4a. Facility Name (If not institution, given	e street and number)	. /		4b. City,		Location of			4c. County		
			PENNSULA REGIONAL	MARKAI C	ONTO	~	Milada	- •	13601	/		M	com	
	Funeral Director		215-12-6690	Sex 7. Age	80	last birthday) Yrs.	If Under Months	Days	If Under	Min	8. Date of Birth (Month, Day, June 19,	1923	Coun	lace (State or Foreign try) Land
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						11	0d. Inside City Limits
	72 hours after death with the Maryland Insturel', or Items 23s or 28s-1 show Occol Examiliser must be motified at	ţō	Maryland Wicon	nico	Sa	lisbur	v							1 ☐ Yes 2 🛣 No
	r 28a	lrec	10e. Street and Number				10f. Zip	Code			10	g. Citizen of V	Vhat Coun	try?
	th witi	Funeral Director	101 Pacific Avenu	ie			21	.804				US	SA	
	ems ems	ıner	11. Marital Status	12. Was Decedent E Armed Forces?			Was Deced	ient of Hi	spanic Orig	in? (Spec	cify Yes or No- lican, etc.)		e - America k, White, e	
36	or It	by Fu	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give	<sup>lo</sup> ₩VI	I	1 ☐ Yes	2 <b>X</b> No	Specify:			Specify	<i>'</i> :	
5-0036	hour tural	ed b	15. Decedent's E	Year or Dates:	Nav	Y 16a, Dece	dent's Usua	al Occupa	ition		1	6b, Kind of Bu		nite
Ϋ́ Ω		plet	(Specify only highest gr	ade completed)	.)	(Give	kind of wo	rk done d se retired,	uring most	of workin	ig .	00, 11,110 01 01	31110331110	
2121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Sales	5				I	Electri	cal S	Supply
	0 = 0 5	Be C	17. Father's Name (First, Middle, Last						18. Mother	r's Name	(First, Middle, M	aiden Sumam	e)	
<u>yla</u>	should be filed withir and Mental Hygiene. Is marked other than sumatic event, the M	5	William Carl		, Sr	1			Sar				stings	
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic engoes.		19a. Informant's Name/Relationship	Type, Print)			10				Route Number,			Code)
	1 and Health sm 27 ther t	-	Veronica Smith 20a. Method of Disposition	(wife)	20b. P	101	Pacif	ic A	venue		lisbury	Maryl		21804
more,	Pages nent of h int: If ite iry or of		1 Burial 2 ☐ Cremation 3	Removal from State	C	emetery, crer	natory or o	ther place	. 1				•	
=	artme artme prtant injury		'4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Par	sons C			Ap s of Facility		27,2004	Salis	bury	, Maryland
Ba	permi Depa Impo any ir	-	Noun 24 10-		FSF				,					
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the deat		er the mod	e of dying	, such as o	cardiac or	respiratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	One cause of each in	o.	/	0	60		D.	2 200			Onset and Death
	/Medical		resulting in death)	a. Due to (or as	conseq	uence of):	- / - /	0	) ^		200			2019
	.Examiner		Sequentially list conditions.	b. S/10	14.	ons	ag	es	n Uz	na				long
о.	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseq	uence of):			C					
_	be executed sicien and burial-transit	хаг	that initiated events resulting in death) Last	c. Due to or as a	conseq	uence of):	27	107					- 9	5 cm
760	The law requires that the death certificate be executed at has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	ical E	l l											
687	ficate physics the	edic		_ d										
ŏ	leath certific attending p I for use as I	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pr	ognanov				23d. Date	e of deliver	у
<u> </u>	death	sicia	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at			Other (sp.					Mor	eth I	Day Year
o.	at the d by the stach	Physician/Med	9 Unknown			to the second					an Bida-b			
Ś	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions	contributing to death bu	it not res	utting in the ui	nderlying ca	ause give	n in Part I.					e cause of death?
0.00	w requir been si should	eted												
Records,	has the 2 s	Completed									24a. Was an autopsy performe	, p	vere autop rior to com eath?	sy findings available apletion of cause of
	ician: Th certificate rector, pag	e Co	25. Was case referred to medical						00.01	-4 D4b	1 ☐ Yes 2	No 1		2 No
Vita		To Be	examiner?	Hospital: 1 Inpatier	nt 2 🗆	ER/Outpatien	t 3 🗆 DO	A Othe			<i>(Check only one,</i> ie 5 ☐ Residen		er (Specify	]
o	g Phy er thi	i.	27. Manner of Death	28a. Date of Injur (Month, Day	У	28b. Time of		8c. Injury Work			8d. Describe how			
201	Attending Ph ar death. octor; After th by the funeral	atio	1 Aatural 5 Pending 2 Accident investigatio	n		,,	М		es 2□N	lo				
Division of		ertification:	3 Suicide 6 Could not be determined				eet, factory	, office		28	8f. Location (Stre City or Town,	et and Numbe State)	er or Rural	Route Number,
	pital ours a neral I	O	29a, Certifier 1 Dertifying Pl	nysicien: To the best of	f mv kno	wledge death	occurred:	at the time	e date and	I nlace ar	nd due to the cau	se(s) and mai	nner as sta	ited
	To the Hospital or within 24 hours afte To the Funeral Dip completely filled in	dical		niner: On the basis of and manner sta	examina									
	To th To th comp	Me	29b. Signature and title of certifier	1/2/	)		290	. License	number		290	d. Date signed	(Month, D	lay, Year)
)	2 111)		277	11/	-		4	72	57	X	8	4/2	5/05	
	514		30. Name and address of person who	completed cause of de	ath (Item	1 23a) (Type,	Print)	-,		/			1-1	
	, VH		William H. Kob	ins 100	E.	Carro	1/5	t.	Salis	SOUR	y, mo	2/80	0/	
	Sta Registr	-	31. Date filed (Month, Pay, Year) APR 2 6	2004 32. Registra	s Signa		1 14	pour	ls/	,				

hysician		1. Decedent's Name (First, Middle, La	1- For Amend Item #4a, per Dr, 981,5/13/2004 Certificate of Death  1. Decedent's Name (First, Middle, Last)  WILBUR ALLEN TAYLOR					ath	3. Time of Death
/Medical		TAYLOR	WILBUT				05 Month	Day Year	4 1:31 P
xaminer	4	a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		4c. County of De	ath N/A
	5	i. Social Security Number 6. S	EX 7. Age (In yrs.	, , ,	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	5/40	irthplace (State or Foreig
neral ector			XM 2□F 85		Months Days	Hours Min.	8. Date of Birth (Month, Day May 22,	1918 Ma	Country) ry Land
127	-	Jsual Residence of Decedent  10a. State 10b. County	10c Ci	ity, Town or Loca	ation				10d. Inside City Limit
other traumatic event, the Middel Exercites results notified at To Be Completed by Funeral Director		MD		ltimor					12 Yes 2 □ N
olicer nated by continual terminal	3	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
ai Dir	3	1520 Ramblewo	od Road		21239			U.S.A.	
or nems 23s	2	1. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 ☐ No	J.S. 13. W.	as Decedent of Hi Yes, specify Cubai	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	nerican Indian, nite, etc.
by F		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Vac Cinc	II 10	☐Yes 2X No	Specify:		Specify:	White
olical Exp	1	15. Decedent's Ed	ducation	16a. Decede	nt's Usual Occupa	ation		16b. Kind of Busines	s/Industry
M M	-	(Specify only highest gra	de completed)  College (1-4or 5+)	life. DO	O NOT use retired,				
t, it a Modeal Completed	5			Denta	l Techn			Prostheti	c Artisan
marked other than imatic event, the M	3	17. Father's Name (First, Middle, Last)				18. Mother's Name		•	
To To		Jesse Allen T		19h Mailing	Address /Street a		McCul	r, City or Town, State,	Zin Code l
rtrau		Rae L. Taylor/						timore, MI	
	2	20a. Method of Disposition	20b. F	Place of Disposit		D	ate	20c. Location - City o	
ייס ליין		1 X Burial 2 ☐ Cremation 3 ☐  1 4 ☐ Donation 5 ☐ Other (Specify	memovarirum state		Cemeter		4	Freeland	, MD
eny injury o		21. Signature of Funeral Services icen	See I	22. I J .	Name and Addres J. Hart	s of Facility Censtein	Mort	ary, Inc	17349
	+	23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that is sed the deat						Approximate
ician	1	Immediate Cause (Final disease or condition	one oddshort art line.						Interval Between
dical		resulting in death)	2 111 11		CAPI	IAI	NCAO	CTIMAL	Onset and Death
		resulting in Geatily	Due to (or as a conseq		CARD	IALI	NFAP	CTION	I weak
niner			b	quence of):	CARD	IALI	NFAR	CTION	week
<b>5</b>		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		quence of):	CARD	IALI	NEAP	LCTION	iweok
I-transit xaminer		Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Cause (Discoss of India) that initiated events resulting in death) Last	b	quence of):	CARD	IALI	NEAR	CTION	week
rial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Sause (Discuss of hipsy that initiated events	b. Due to (or as a conseq	quence of):	CARD	IALI	NEAR	2CTION	week.
rial-transit		Sequentially list conditions, of any, leading to immediate cause. Enter Underlying cause, Cacces of white you hat initiated events resulting in death) Last	b. Due to (or as a conseq	quence of):	CARD	IALI	NFAF	CTION	weok
rial-transit		Sequentially list conditions, frany, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (or as a conseq	quence of): quence of): quence of):	CARD ctopic pregnancy	IALI	NFAF	23d. Date of de	livery
rial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1    Yes	b. Due to (or as a conseq c. Due to (or as a conseq d	quence of): quence of): quence of): ancy		IALI	NFAF		Iweek
by the attending physician and ached for use as the burial-transit hysician/Medicai Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a conseq c. Due to (or as a conseq d	quence of): quence of): quence of): quence of): quence of): quence of): quence of):	ctopic pregnancy hther (specify)	1.		23d. Date of de Month	alivery Day Year
be detached for use as the burial-transit  by Physician/Medical Examiner		Sequentially list conditions, of any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	b. Due to (or as a conseq c. Due to (or as a conseq d	quence of):  quence of):  quence of):  ancy al death 3 E feath 5 C	ctopic pregnancy Other (specify)	n in Part I.	23e. Did tol	23d. Date of de Month bacco use contribute t	elivery Day Year to the cause of death?
be detached for use as the burial-transit  by Physician/Medical Examiner		Sequentially list conditions, of any, leading to immediate cause. Enter Underlying cause Decease of hinery that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown Part II. Other significant conditions of	b. Due to (or as a consequence of pregnant at time of deput institution of the contributing to death but not research of the contributing to death but not research of the contributing to death but not research of the contributing to death but not research of the contributing to death but not research of the contributing to death but not research of the contribution of the contributio	quence of):  quence of):  quence of):  ancy al death 3 = 6 leath 5 = 6  sulting in the under	ctopic pregnancy Other (specify) erlying cause give	1.	23e. Did tol	23d. Date of de Month bacco use contribute tes 2 No 3 P	elivery Day Year to the cause of death?
as been signed by the attending physician and 2 should be detached for use as the burial-transit pleted by Physician/Medical Examiner		Sequentially list conditions, of any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	b. Due to (or as a consequence of pregnant at time of deput institution of the contributing to death but not research of the contributing to death but not research of the contributing to death but not research of the contributing to death but not research of the contributing to death but not research of the contributing to death but not research of the contribution of the contributio	quence of):  quence of):  quence of):  ancy al death 3 = 6 leath 5 = 6  sulting in the under	ctopic pregnancy Other (specify) erlying cause give	n in Part I. SECTACER	23e. Did tol	23d. Date of de Month  bacco use contribute te ses 2 No 3 P	elivery Day Year  o the cause of death?  probably 4 @Unknown  utopsy findings available completion of cause of
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Phillip Torsani Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02956 State of Maryland / Department of Health and Mental Hygiene
Unpend Item #23a827 per me 6332 6/2/04 tas

Certificate of Death

Beg, No. RPD Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 1, Year **Physician** 2004 0759 A M Philip Jav Torsani /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Sta Country)
Apr. 26, 1963 France 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Vrs 41 Director 135-64-9887 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 77 is markad other than "natural", or Itams 23a or 28a-f shov traumatic evant, the Medical Examinar must be notified at 1 □XYes 2 □ No Director MD Prince George's Bowie 10e Street and Number 10g. Citizen of What Country? 10f Zin Code USA 12324 Rambling Lane 20716 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Design Director Graphic Design 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Joseph A. Torsani Faith A. Hancock ၉ of Health and Nitam 27 is mail 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy E. Torsani / spouse 12324 Rambling Lane Bowie, MD. 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ō **=** 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem, 5-6-2004 Alexandria, 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Lic 6512 NW Crain Hwy. Bowie, MD. 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Seizure Disorder /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

■ Yes 2□ No 24a. Was an page 2 has autopsy performed? certificate Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 2 €R/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) funeral 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 house the Funaral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. ture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sigha O.C.M.E. Mprie May 2, 2004

State Registrar

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Korou

32. Registrar's Signature

ARYARITO

Month, Day, Year)

MAY 0 4 2004

			For State Registrar	State of Man	/land / Dep		lealth and I		giene 200	4 15499	
			Decedent's Name (First, Middle, Last)					2. Date of D		3. Time of Death	
0	Physici /Medio Examir	al	Roger N. Tr	uehart street and number)		4b. City, Town, or	Location of Death	April	24 2004 4c. County of Dea	9:00 PM	
	Lxamii	161	Southern Maryl	and Hospi	ta1	Clinton	n		Prince G	eorge	
MC	Funeral		5. Social Security Number 6. Sec. 172	TM OFF	n yrs. last birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D		rthplace (State or Foreign ountry)	
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	with ti	Dir	10e. Street and Number			10f. Zip Code				ountry:	
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and	2 should be filed within and Mental Hygiene. is marked other than eumatic event, IZE M	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle	e, Meiden Sumame)	•	
yla	ould to Ment	٩	Henry E. Trueha		40h M-11	Add (Chroat	Ruth S		ber, City or Town, State,	Zin Codol	
Mary	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (7) Nannie Gilliam						naton, DC		
4 - altimore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	pe)	Date	20c. Location - City o	r Town, State	
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. B	death e atter	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	blivery Day Year	
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<b>\(\bar{\bar{\bar{\bar{\bar{\bar{\bar{</b>	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatie	nt 3 DOA Othe	26. Pface of Dea er: 4 ☐ Nursing H		onej sidence 6 ⊡Other (Spe	ecify)	
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Sivisi	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Pface of Injury building, etc. (5	- At home, farm, st Specify)	reet, factory, office		28f. Location City or To	(Street and Number or Fown, State)	dural Route Number,	
_	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C			amination and/or in				cause(s) and manner a , date and place, and du		
	To the within 3	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (Mon	th, Dey, Year)	
•			30. Name and address of person who co		h (Item 23a) (Type		66582		4/25/3 FORT W	2004 ashinaton	
CF.	(0)		30. Name and address of person who de land 180 NE M 31. Date filed (Month, Day, Year)		5 FORT	Washin	glon Rd.	#206	MA	20764	
	St Regist	ate rar	APR 2 9 2004	Klin	# for	W	*				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 1:40 P M WILLETTE C. THORNES 4 26 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S 7605 LOCRIS DRIVE UPPER MARLBORO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 26 1 5. Social Security Number **Funeral** Days Hours Min. 1 □ M 2 € F 162-30-0777 70 Yrs. South Carolina 1934 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director UPPER MARLBORO PRINCE GEORGE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. or itams 23a 7605 LOCRIS DRIVE 20772

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after t Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Black Specify: 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th than College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Italia. Project Manager Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William H. Caldwell Flossie Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Thorns/Daughter 7605 Locris Drive Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veteran's 5/5/2004 \* 4 □ Donation 5 □ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer unth don resulting in death) /Medical for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transit Exam pertension and Due to (or as a consequence of) Box 68760. signed by the attending physicien Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No detached P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 8 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 No Division of Vital director, Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2 No 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: After Injury 1 Natural 5 ☐ Pending 1 Tes 2 No death. investigation 2 Accident completely filled in by the within 24 hours efter death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ۽ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 019518 Kosario 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSARIO Registrar's Signature PERNANDEZ HD OLD BRANCY AVE. CLOS CLINTON 31. Date filed (Month, Day, Year) State APR 2 8 2004 Registrar